KRG Care Homes Limited

Manor Farm Care Home

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Manor Farm Care Home provides care and support to a maximum of 25 older people, some of whom were living with dementia. At the time of our visit there were 23 people using the service.

The inspection was unannounced and took place over two days, on 3 February 2017 and 7 February 2017.

The home had a registered manager in place. 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 requirements in the Health and Social Care Act 2008 and associated regulations about the service is run.

We identified significant shortfalls in the care provided to people using the service. This was linked to a lack of oversight from the registered manager, deputy manager and provider.

People were put at risk of significant harm in the absence of clear records and assessments which reflected all current areas of risk and how these should be managed to protect the person from harm.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

People were not supported to maintain good nutrition, and action had not been taken by the service to reduce the risk of people becoming malnourished.

People were not supported to live full, active lives and to engage in meaningful activity within the service. We observed that some people were socially isolated and disengaged from their surroundings. Some people made negative comments about the sources of activity on offer. This had not been independently identified by the service so no action had been taken by the registered manager to address this.

People's care plans and assessments were generic and not person centred. Care planning did not include enough information about people's past lives and experiences for staff to understand them. People and their representatives were not consistently involved in the planning of their care, and their views were not reflected in their care records.

People told us and we observed that there were not enough suitably trained and experienced staff available to meet people's social, emotional and physical needs. Staffing levels were not calculated by the management based on the needs of people using the service and there was no system in place to monitor the effectiveness of the staffing numbers.

Staff were not consistently supported to develop their skills within the caring role. There was no system in

place to assess staff competency and performance. Supervision and appraisal of staff was not carried out consistently and it was unclear how staff skill was developed to ensure the care provided to people was of good quality.

Systems in place to monitor the quality of the service were ineffective in identifying shortfalls and areas for improvement. There was not an open culture within the service. The managers were not visible and did not take a leading role in directing care staff. A health professional told us they did not know who the manager was, and people told us they did not see the managers very often.

Staff recruitment was conducted in such a way that ensured prospective staff had the skills, background, experience and knowledge for the role.

Medicines were managed and administered safely by staff. Improvements were required to ensure protocols for the administration of 'as and when' (PRN) medicines were available to staff.

Throughout the two inspection visits we identified such serious concerns that we fed these back to the registered manager so action could be taken to protect people from harm. In addition, we shared information about the concerns we identified with the local council's safeguarding team and local commissioners. Following the inspection, we wrote to the provider to request information about how they intended to make the urgent improvements required to protect people from the risk of coming to significant harm.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not identified, planned for and managed appropriately. The management was not proactive in protecting people from risks.

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

Is the service effective?

Inadequate

The service was not effective.

The service was not complying with legislation around the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

People were not supported to maintain healthy nutrition.

Care staff did not receive appropriate consistent supervision and appraisal in their role.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Whilst staff demonstrated care for people, widespread failings meant that the service did not promote a caring atmosphere and people did not always receive the care they required.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some people were disengaged, bored and did not have access to appropriate stimulation and activity.

People and their representatives were not consistently involved in the planning of their care.

People's care records were not consistently person centred, and

did not reflect in sufficient detail people's preferences or interests.

People had the opportunity to feed back their views at meetings and knew how to complain about the service. However, meetings were infrequent and people and their relatives were provided with no other means of expressing their views on the service.

Is the service well-led?

Inadequate

The service was not well-led.

The quality assurance system in place was ineffective in identifying serious shortfalls which led to people receiving poor care.

Whilst we observed good practice from the care staff, the management did not promote an open, transparent and inclusive culture in the service.

Manor Farm 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on over two days on the 3rd and 7th February 2017 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we examined previous inspection records and notifications we had received. A notification is information about important events which the service is required to tell us about by law.

We spoke with seven people who used the service, three members of care staff, the registered manager and the deputy manager. We looked at the care records for nine people, including their care plans and risk assessments. We looked at staff recruitment files, medicine administration records, minutes of meetings and documents relating to the quality monitoring of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

We found that the service was failing to assess people's risk of developing a pressure ulcer and were not undertaking Waterlow assessments to assess this risk. Waterlow assessments score people's level of risk based on a number of factors such as their weight and ability to mobilise. As a result of failing to determine people's level of risk, the service was not guided by accompanying guidance to put in place preventative measures to reduce the risk to people.

There were no care plans to guide staff on how to manage people's pressure care. One person was identified to us by the manager as having a current pressure ulcer. They told us this person was being repositioned regularly to reduce the risk of their skin breaking down. However, it was not noted in their care records that they had a current pressure ulcer and required repositioning. The senior carer on duty told us they were not being repositioned. It was unclear how this person was being supported to avoid further deteriorations in their skin integrity.

A visiting health professional raised concerns with us about how the service was managing people's pressure care. They told us they found that one person's pressure mattress had completely deflated and that staff told them they had been attempting to inflate the mattress but it kept deflating. This healthcare professional told us no immediate action had been taken by the management of the service to order a new mattress. The management of the service told us they had instructed staff to continue trying to inflate the mattress, but had not ordered a new one until the healthcare professional visited. They could provide no records of the incident, so we were unable to ascertain how long the person had been lying on this deflating mattress. The inaction of the management team meant this person was exposed to uncontrolled risk which could have resulted in them coming to harm.

We found that the service was failing to have in place adequate control measures to protect people from the risk of falling. There was no care planning around falls to guide staff on how to support people to mobilise safely. Where people's care records noted they had been referred to the falls prevention team, the outcome of this referral and the guidance received from the team had not been included in their care records. One person whose records we reviewed had sustained two injuries as a result of falls in the months prior to our inspection. Their mobility care plan stated they required the assistance of one carer and a walking frame to mobilise safely. However, we observed that this person did not have the assistance of a carer whilst mobilising during our inspection. In addition, they did not have full use of one of their arms following injuries they sustained in two previous falls. This put the person at an increased risk of falling and sustaining further injuries. In the care records of another person, it stated they had been urgently referred to the falls prevention team, but there was no care planning or risk assessment around how staff should reduce their risk of falling. Their mobility care plan guided staff to 'try with walking stick' but didn't state if this method had been decided upon as the safest option for the person. No further information was available to guide staff on supporting the person to safely mobilise.

We found that risk assessments in place for people were generalised and did not always take into account certain risks to individuals. In addition, risk assessments did not always detail adequate control measures to

reduce the risk of the person coming to harm.

The information in risk assessments was not always included in care planning. For example, one person had a risk assessment in place for choking. However, this risk was not reflected in their care planning. There were no detailed instructions for staff on how to reduce the risk of the person choking at meal times.

There was no formal system in place to ensure that care planning and risk assessments reflected people's current needs. For example, the Personal Emergency Evacuation Plans (PEEP) for two people whose records we reviewed did not reflect how they currently mobilised. One person's evacuation plan stated they would be able to safely evacuate the building in case of emergency with the aid of one carer and a walking stick. However, their mobility care plan stated they now required the assistance of two members of staff and a stand aid. Another person's evacuation plan stated they would be able to safely evacuate the building with the support of one carer and a walking frame. However, in their mobility care plan it stated they often now required a wheelchair. This put these people at risk of coming to harm in the event of an emergency evacuation.

There was no formal system in place to analyse incident records and ensure that appropriate records of incidents were kept. Actions were not put in place following incidents to minimise the risk of these reoccurring. We found that there was no record for one incident that a healthcare professional told us about. The manager was aware of the incident but did not check that an incident record had been completed. The registered manager told us they were made aware of incidents when they happened, but did not undertake any formal review of these to look for trends. For example, the manager did not analyse falls to ascertain whether people were falling at certain times of the day when there were less staff available. It was unclear how the management of the service would know of falls and other incidents that occurred outside of their working hours.

The management of the service had not ensured that checks on the safety of equipment were completed regularly. Whilst some larger equipment such as hoists and stair lifts had been serviced by an external company, we found that safety checks on other equipment had not been completed since October 2016. These included checks to ensure wheelchairs, walking frames, window restrictors and call bells remained in good working order. The manager was not aware that these checks were overdue until we identified this during our inspection. There was a blank record relating to checks on the rubber feet (ferrules) on walking frames. The manager told us they did not believe those checks had taken place. We found that the rubber feet on several walking frames in use were worn and required replacement. This meant that their grip on the flooring was compromised which could lead to the frame slipping and the person falling.

This was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

We found that there were not always enough staff available to support people in a timely manner. Whilst some people told us staff attended to them promptly, some people told us staff were slow to respond. One person told us, "They are very rushed, it's not their fault but it takes them a while to get up to me." Another person said, "I do worry about it, sometimes I call but they're busied with someone else." One other person commented, "They used to have more but its [staffing level] gone down. I'm ok getting myself up and ready but I worry about the people who need all the help." People said staff didn't always have much time for them. One person said, "They try and try but with the best will they don't have enough hands. I can't expect them to sit and talk to me when they got other people needing their help." Another person told us, "They're shorthanded definitely. Don't get much time with them, but I have friends here and that helps."

A visiting health professional we spoke with raised concerns with us about the number of staff available. They told us that they rarely saw any kind of stimulation or activity ongoing in the service when they visited, and said they were concerned that people were left alone in communal areas with no staff present.

Whilst staff we spoke with told us they felt the staffing level was satisfactory, the manager acknowledged that the staffing level had been reduced the previous year at the request of the provider. The manager said they had raised this as an issue, as they felt more staff were needed to meet people's needs, including their social and emotional needs.

We noted from speaking with the manager that senior carers took responsibility for many other duties outside of caring for people. These included supervision and appraisal of care staff and the reviewing and updating of care plans. This meant that senior carers were not often able to assist care staff to meet people's needs.

We observed that at certain times of the day, staff struggled to meet everyone's needs fully. At meal times, there were five care staff available to support people to eat. However, there were three people in the dining room who required full assistance to eat and other people in their bedrooms who required assistance. We observed this meant other people seated in the dining area who occasionally needed assistance did not receive this support when they needed it.

The service did not use a dependency tool to ascertain how many staff were required to meet people's needs. A dependency tool is a way of assessing the needs of people against the time it would take staff to meet those needs. In doing that, a calculation of how many staff are needed at any one time can be obtained.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

We found that medicines were stored and administered safely. People told us they received their tablets on time, one person said; "They bring the pot [with tablets inside] on time and I just take them. Easy." Another person told us, "Very prompt, never have to remind them."

The service did not have in place protocols for 'as and when' (PRN) prescribed medicines. A PRN protocol is a document which sets out information about a medicine that a person may only need to take on certain occasions. This should clearly set out what the medicine is for, the reasons the person may need the medicine and how it should be administered.

We recommend that the service puts in place these protocols for anyone taking an 'as and when' (PRN) medicine.

The service practiced safe recruitment procedures. This included obtaining references and criminal records checks before staff commenced work to ensure they had an appropriate character for the role.

Inadequate

Is the service effective?

Our findings

We identified that action was not always taken to protect people from the risks of malnutrition. Records confirmed that 14 people were underweight or had lost weight at the time of our inspection. There were no effective management plans in place to reduce the risk of these people continuing to lose weight and becoming malnourished.

It was not clear what action had been taken by the service where people were underweight or had actively lost weight. For example, one person had lost 13 pounds in a two month period but records did not demonstrate that the reasons for this weight loss had been explored or acted upon. The service was unable to tell us what action had been taken to protect the person from the risk of malnutrition. Where records indicated some people had been referred to a dietician, the outcome of this referral or the guidance provided by the dietician was not documented in the persons care records. For other people, the service could not demonstrate these referrals to other professionals had been made where it would have been appropriate. Some people were having their food intake monitored. However, where people had not eaten much, it was unclear how the service identified this and took action. For example, if someone ate little of their lunch, the service could not evidence that they had attempted to offer the person meals or snacks later in the day. Staff told us that a tea trolley with biscuits was provided at scheduled times but that they did not actively offer people with extra snacks to boost their nutritional intake outside of these times.

The service was not using the Malnutrition Universal Screening Tool (MUST) to assess the risk to people and therefore had not taken the action specified in the MUST guidance. For example, where people are assessed as at risk of malnutrition, the guidance states they should be weighed weekly so their weight could be more closely monitored.

This was a breach of Regulation 14: Meeting nutritional and hydration needs of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA.

People were put at risk of having their rights and liberties restricted unlawfully because the service was not following legislation around the MCA and DoLS. Staff we spoke with demonstrated they understood MCA and DoLS and we observed that staff asked people for consent before supporting them. However, the service had not assessed people's capacity appropriately. For example, the care records for some people stated they did not have capacity. However, there was no accompanying assessment to evidence how this

determination of capacity had been made. We observed other people in the service who required an assessment of their capacity to make some decisions, but this had not been completed. For example, some people were seated in chairs that tipped back, which prevented them from getting out of the chair independently. Other people had movement mats in place, which meant that staff would be alerted if they moved from their chair or left their bedroom. There was no information to support that the service had followed a formal best interest process with other appropriate agencies to come to a determination about whether these interventions were in the person's best interest and the least restrictive option.

This was a breach of Regulation 11: Consent to Care and Treatment of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

The management did not have in place an effective system to ensure that staff had opportunities to develop and improve within their role. Staff competency and practice was not assessed. This meant the management team was unable to evidence how they ensured the training staff received provided them with sufficient knowledge to provide safe and effective care to people.

We reviewed the supervision and appraisal records for care staff and found that these had not been completed consistently in the year prior to our inspection. The managers told us that supervision and appraisal of care staff was delegated to senior carers, who each took responsibility for a group of staff. However, the managers had not identified that senior carers had not been keeping up to date with these duties.

Two supervision records that were available from 2016 were brief, and did not evidence that these sessions were used to discuss training and development or to encourage staff excellence. The managers told us that senior carers had not received training on conducting these sessions and that they did not carry out any checks on the quality of the supervision sessions conducted by senior carers.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People told us they were happy with the knowledge and skills of the staff supporting them. One person said, "I can't complain in that respect, they do everything very well." Another person commented, "They seem to know it all." One other person told us, "They go about their business with purpose, I'm happy with [them]." Staff received training in subjects such as moving and handling, food hygiene and safeguarding. At the time of our visit all care staff were up to date with their mandatory training. Staff told us they were happy with the training they received and made no suggestions of any further training they felt they needed.

The deputy manager told us that new staff had an induction day where they completed all their mandatory training. In addition, new staff carried out three shadow shifts in order to get to know the people using the service. Shadow shifts are where a new member of staff observes and assists another carer. These arrangements for new staff were confirmed by a carer who had recently started work at the service. They told us they felt the training and induction they received was sufficient, and said that they could have completed more shadow shifts if they didn't feel ready to carry out a shift alone.

People made positive comments about the meals they were served in the service. One person said, "They are top class, couldn't be better." Another person told us, "They recently got a new chef in and things changed at first and I wasn't sure. But the dinners have been really good." Another person commented, "Brilliant, restaurant quality."

We observed the lunch time meal and saw that people were given choices of where they would like to sit, and offered a variety of drinks with their meals including a glass of wine. We were told people were given an opportunity to choose their meal for the following day, and this was confirmed by one person who said; "You get a menu to choose for the next day. There are a few good choices on there." We observed that two people asked for something different once their meal had been served, and these requests were catered for without question.

Meals were served to people quickly; however, improvements could be made around ensuring entire tables were served one at a time. In addition, improvements could be made to ensure that those requiring softer food or full assistance to eat did not wait too long for their meal after everyone else had been served.

People were provided with specialist equipment which enabled them to eat independently, such as adapted cutlery or crockery.

People told us they could have support from external healthcare professionals such as GP's when they required it. One person said, "You don't need to ask if you are ill, they just call someone for you." Another person told us, "The doctor is in regularly and if you need seeing to the staff ask them to check on me." Improvements are required to ensure that the service keeps accurate records of the treatment people received from external health professionals.

Requires Improvement

Is the service caring?

Our findings

We identified widespread failings across the service which meant that people did not always receive the care and support they required to uphold their health, dignity, safety and welfare.

The management team had failed to independently identify these failings and take action to improve the quality of the care people received. This meant that the management team did not promote a culture focused around good practice.

Whilst we observed that staff were kind to people, they were failing to identify and address the poor practice of themselves and other staff members. This meant people were put at risk of harm and received care that did not always meet their needs.

Staff were not implementing the Mental Capacity Act (MCA) effectively, and this meant that they were not promoting independent decision making.

Improvements were required to ensure that care records reflected the tasks people could complete independently. For example, the parts of their personal care routine they could complete themselves and the parts they required staff to support them with. This information could reduce the risk of staff over supporting people and limiting their independence.

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People told us and we observed that staff were kind and caring towards them. One person said, "They are so, so kind. They do genuinely care." Another person told us, "They show me a lot of care and respectfulness."

We observed many kind and caring interactions throughout our visits. Staff responded to people when they appeared distressed or requested support. For example, we saw one person calling out with their head in their hands. Staff promptly attended to the person, comforting them with reassuring touch and discreet discussion about how they could help. We saw another staff member trying several techniques to engage a person with limited communication, including speaking to them in another language they were fluent in. We saw that the person responded to this with facial expressions and by nodding their head. At lunch time we observed this staff member supporting this person with their meal in an encouraging manner, speaking to them in light upbeat tones that made the person smile.

It was clear from our observations that staff knew people well, and conversed with them about topics they were interested in, such as what was happening in a particular television series. People told us they felt listened to by the staff, and that they felt what they said mattered to staff. One person commented, "I am listened to, if I'm not happy they do their utmost to change that." Another person said, "I did mention one thing once that I wanted to change and [staff] did get it done."

People told us they were given the privacy they wished for. One person commented, "If I don't want bothering, they won't bother me." Our observations demonstrated that staff respected people's right to privacy, ensuring they knocked on people's bedroom doors before entering and asking them if it was OK for them to come in. Staff ensured people's dignity wasn't compromised by carrying out personal care and sensitive tasks in private and by ensuring discussions around people's care were discreet.

Requires Improvement

Is the service responsive?

Our findings

People told us they did not feel they had much involvement in the planning of their care. One person said, "I talked about it when I first come in but I haven't since." Another person told us, "They do reviews, I know that. I don't know what is written about me." Another person commented, "I'm not sure what they have in my plans, I didn't really know I had any." Improvements were required to ensure that people were involved in all aspects of their care planning, and that their views were clearly reflected in their records.

Care records for people were not sufficiently person centred and did not adequately reflect their individuality. There was limited information available in people's care plans about their hobbies, interests and personal preferences. For example, care plans stated a person liked music or television programmes. However, there was no information about the type of music they enjoyed or what television programmes they liked to watch. With regard to food and drink, some people's records stated they enjoyed 'traditional' food, but didn't expand upon their specific preferences.

There was limited information available about how people with specific communication needs engaged with staff. For example, one person's care plan stated they did not verbally communicate but would communicate via facial expression. However, there was no further information about what facial expressions the person may make and what these expressions meant in terms of the support they may require. This information would allow staff to develop better methods of communicating with each individual in a meaningful way.

There was limited information consistently available about the life history and experiences of people living with dementia. For example, we spoke to a staff member about one person who displayed behaviour that challenged staff. This staff member told us about a time in the person's life which they felt was being replicated in certain behaviours. Information about this significant life event was not included in the care records for this person. This information could support staff to understand people's individual needs with regard to how dementia affected them in their daily lives. This information would also allow staff to provide more personalised care.

At the time of inspection a new member of care staff had recently started working at the service. It was unclear how this member of staff and future new staff would be able to get enough information about people from their care plans to provide them with person centred care.

People were not consistently protected from the risks of social isolation and loneliness because staff did not always support people to engage in meaningful activity or stimulation. There was no system to ensure that people who were particularly at risk of under stimulation or isolation were protected from this risk.

Staff did not support people to enjoy their individual interests and hobbies. A staff member told us it was the responsibility of all care staff to engage people in activity. However, they said it was often difficult to find the time to support people to engage in activity. One person using the service told us, "Not much goes on, the occasional game of bingo but I don't like bingo. And I don't want to do exercises either. That's pretty much

all there is, so it doesn't interest me." One other person said, "Well we do bingo sometimes or exercises", but they couldn't tell us what other activities were offered to them. We observed that some people in the communal areas of the service were disengaged with their surroundings and had not been engaged in any meaningful activity throughout the day. One person sat with their head in their hands for most of the day. Whilst staff checked on the person and asked if they needed anything, no attempt was made to try and engage them in an activity. This meant that people were not consistently supported to live full and active lives.

This was a breach of Regulation 9: Person centred care of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People told us they had attended a residents meeting in January 2017, but said there was a long gap between this and the previous meeting. One person said, "We had a meeting in January, the one before that was ages ago. I like to go but I sometimes think [managers] can only do what they can do. The activities could be better and I've said it before but I don't know if the managers can sort that." Another person commented, "We do get asked if we want to go to meetings. Not very often." The managers confirmed there was no other formal method of obtaining people's views on the service. For example, they did not carry out surveys of people's views. This meant that people's opinions and experiences were not used to influence the running of the service.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People told us they knew how to make complaints and felt these would be listened to. One person said, "I know how to complain if I needed to." Another person told us, "I would tell the seniors, heart of gold they have." One other person commented, "I don't think I'd have to but I would know how to go about [making a complaint]." The service had in place an appropriate complaints policy and procedure, and this was displayed publically in the service. At the time of our inspection the service had not received any complaints.

Inadequate

Is the service well-led?

Our findings

There was no effective oversight of the quality of the service from the provider, registered manager and deputy manager. During feedback at the conclusion of the inspection, the registered manager and deputy manager told us they were surprised they were not going to receive a rating of 'good'. We were concerned that the managers had failed to identify that in some areas the service fell far below the standards required to meet the regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When we shared the concerns we had identified with the registered manager, they were unaware of these.

Quality monitoring processes were ineffective and did not identify poor care which put people's health, safety and welfare at risk. For example, there was no formal system in place to monitor people's weight. This meant that clear action had not been taken to put in place plans to protect 14 people from the risk of malnutrition. Similarly, there was no formal system in place to monitor whether care plans were up to date and reflected people's current needs. This meant that some care plans reflected inaccurate information in area's such as how people mobilised, or how they would exit the building in an emergency. This put people at risk of not receiving the support they required to protect them from harm.

Where duties such as reviewing and updating care plans and supervising and appraising staff had been delegated to senior carers, the managers failed to monitor whether these duties were being completed to an adequate standard. Similarly, the management had no process in place to monitor whether checks completed by maintenance staff had been completed. We found that several checks, including safety checks, had not been completed since October 2016. When we asked the manager whose responsibility it was to ensure these were done, they acknowledged it was their responsibility but that they had not identified that these checks had not been completed.

Where potential areas for improvement were identified in medicines audits carried out by an external company, we found that the manager had repeatedly failed to make the improvements suggested. For example, an external audit of medicines in June 2015, December 2015 and May 2016 identified that PRN protocols were not in place for 'as and when' medicines. A PRN protocol is a document which sets out information about a medicine that a person may only need to take on certain occasions. No action had been taken to put these in place. In an internal medicines audit carried out by the registered manager in November 2016 and January 2017 it states there were PRN protocols in place. However, we identified these were not in place.

People told us the managers were not always visible within the service. One person said, "I see them from time to time, but not much considering they are here most days." Another person told us, "They stay holed up in their office most of the time." This was corroborated by a visiting health professional, who told us they were unaware who the managers were. We observed during our inspection that the managers were not overseeing and directing care staff. For example, neither the registered manager or deputy manager were present to observe lunch on either day of our inspection. We were provided with a job description for the deputy manager which stated one of their duties was to observe lunch.

Staff were not given an opportunity to be involved in the development and improvement of the service. Meetings with staff had not been taking place regularly. The deputy manager acknowledged that these had not been as regular as they should be and stated this was something they intended to improve upon. We were not assured that staff received consistent support from the management of the service which encouraged a culture of openness and transparency.

There was no system in place to analyse incidents such as falls. The manager told us that they were made aware of incidents when they happened, but did not undertake an analysis of incident forms before these were filed in people's individual care records. This meant the manager did not have oversight of incidents within the service.

At the conclusion of our inspection visit on 3rd February 2017 we provided the managers with written feedback about our most serious concerns. On our second inspection visit we were concerned that the managers had not prioritised the work that needed to be completed. For example, they had created a new PRN protocol document and food chart but had not commenced assessing risks to people with Waterlow and MUST assessments. We were so concerned about people's welfare that we wrote to the provider of the service to urgently request an action plan to reassure us the risks to people were being mitigated. We received an adequate action plan on 13th February 2017, which assured us that no urgent enforcement action was required at that time.

We shared our concerns with the safeguarding team at the local authority following our visits so that we could work in a joined up way to ensure people were protected from immediate harm.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.