Community Integrated Care

Hesketh House 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

This inspection took place on 28 October and 9 November 2016 and was unannounced. This meant the provider was not aware we were intending to inspect the home. A previous inspection, undertaken in July 2014, found there were no breaches of legal requirements.

Hesketh House is located on an old hospital site within a residential area of Wavertree, Liverpool. There are fourteen single bedrooms available for people with a learning disability, who require assistance with personal or nursing care. Communal areas include a dining room, a lounge, sensory area and a large garden with a terrace. At the time of the inspection there were 13 people using the service.

A registered manager was registered for the location and our records showed he had been formally registered with the Care Quality Commission (CQC) since October 2010. A registered manager is a person who has registered with the CQC 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.

Staff had received training with regard to safeguarding issues and demonstrated an understanding of potential abuse. They told us they would report any concerns to the registered manager. We noted one potential safeguarding incident, raised by a trainee, had not been formally recorded as being investigated. We could not be sure the matter had been dealt with in an appropriate manner. Easy read information about safeguarding was not always available. Risk assessments in people's care plans were not comprehensive and it was not clear they had been effectively reviewed. Personal evacuation plans, to support people in an emergency, had not been reviewed and updated.

Staff told us they felt there were not always enough staff to meet people's individual needs and keep them safe. There was no formal assessment of people's dependency and no available system to determine how staffing levels should alter to meet people's changing needs.

Where people were supported with their medicines we found care plans for "as required" medicines were not always available and some creams were out of date or were not labelled with people's name, to ensure they were used appropriately. One person's fluid thickener had been left on an open trolley posing a potential risk that other people may use it inappropriately.

Suitable recruitment procedures and checks were in place, to ensure staff had the right skills to support people at the home. The home was generally clean and tidy and free from odours.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The registered manager told us some people had been subject to DoLS but these had lapsed in April 2016 and had failed to be renewed or reviewed. Where people did not

have capacity to make decisions for themselves there were no clear best interests decisions recorded, as required by the MCA.

Kitchen staff had knowledge of specialist dietary requirements and supported people to make choices through the use of picture cards. People were not always supported with meals appropriately and in line with professional guidance, putting them at potential risk of choking. Records relating to food and fluid in take were not completed contemporaneously or by the staff who had directly supported people, meaning we could not be sure they were up to date and accurate.

Staff confirmed they had access to a range of training and records showed mandatory training was up to date. More specialist training to support people's particular needs was not in date. Staff told us, and records confirmed regular supervision took place. Some annual appraisal documents were available and the regional manager told us not all had been completed due to change in the system used by the provider.

People's health and wellbeing was monitored, with regular access to general practitioners and other specialist health or social care staff. Specialist advice from health professionals was not always followed or detailed in care plans.

Staff demonstrated an understanding of people's particular needs and personalities. However, people were not always treated with respect and dignity as some care staff talked inappropriately about them and in front of them. Dignity was maintained during the provision of personal care.

Care records contained some good information about people as individuals. However, assessments did not always take into account available information and care plans did not always reflect professional advice. Reviews of care plans and risks associated with the delivery of care were not always detailed. There was evidence of some activities at the home, although a sensory room had not been available to people for over a year, as it had been used for storage. There had been no recent formal complaints. A relative told us they knew how to raise a concern, if necessary.

Audits and checks had not always been undertaken or identified the short falls highlighted at the inspection. The previous regional manager had not undertaken any checking visits and the provider's quality team had not followed up required actions. Daily records were not up to date or well kept. There were gaps in important records such as those monitoring people's weight.

The registered manager and registered provider had failed to notify the CQC of certain events at the home they are legally required to do so.

We found seven breaches of regulations. These related to person centred care, dignity and respect, need for consent, safeguarding, safe care and treatment, good governance and staffing. We also found the provider in breach of the regulation that requires them to notify the CQC of events at the home.

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.

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.

We could not be sure potential safeguarding matters had been formally and appropriately dealt with. Risk assessments were not detailed or effectively reviewed. Personal evacuation plans had not been reviewed.

Systems to assess people's dependency needs and staffing levels were not effectively in place. Medicines were not always managed effectively and safely.

Appropriate recruitment processes were in place to ensure staff had the right skills. Checks on equipment had been undertaken and the home was clean and tidy.

Is the service effective?

Inadequate

The service was not effective.

Previously granted Deprivation of Liberty Safeguards (DoLS) orders had lapsed and not been renewed. There was limited evidence appropriate best interests decisions had been undertaken, where required.

A range of food and drink was available at the home and specialist diets were supported. Note had not been made of people's likes and dislikes. People were not always supported appropriately with food and drink. People had access to health professionals although their advice and guidance was not always included in care plans.

Staff mandatory training was up to date. However, some more specialist training to support people's particular needs had not been updated. Supervision sessions had been undertaken and annual appraisals were in the process of being completed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff talked over people's heads during meal times and some

staff spoke inappropriately about people. At other times there were good relationships between people and staff. Personal care was delivered in a way that maintained people's dignity.

Staff had a good understanding of people as individuals and the non-verbal signals that indicated their needs and feelings. A relative said they were involved in their relation's care, although no relatives' meetings had taken place within the last 12 months.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect the advice and guidance from professionals, or other available information. Reviews of plans were limited and it was not always clear that risks had been reassessed as part of the review process. Some care plans had not been reviewed on a regular basis, despite there being a potential risk.

Staff told us there were activities for people to participate in. Staff said people would benefit from access to a sensory room. The sensory room had been out of action for over a year, despite an action point from a quality visit that it was to be brought back into use.

There had been no formal complaints recorded in the previous 12 months. A relative told us they knew how to raise a complaint.

Is the service well-led?

Inadequate

The service was not well led.

Effective audits on the quality and standard of care at the home had not been undertaken. Self-audits by the registered manager did not reflect the situation found at the inspection. Oversight by a regional manager and the provider's quality team had not been robust.

Records were inappropriately completed and not well maintained.

The registered manager had not notified the CQC of certain events at the home they were legally required to do so.

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Hesketh House 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 28 October and 9 November 2016 and was unannounced. This meant the provider was not aware we were intending to inspect the home.

The inspection team consisted of one inspector and an Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths.

Not everyone who lived at the home was able to speak directly with us. We spoke with three people who used the service and one relative, to obtain their views on the care and support they received. Additionally, we spoke with the registered manager, deputy manager, two nurses, four care workers, the cook and a member of the domestic team. On the second day of the inspection we spoke with the regional manager for the home and one of the provider's project managers.

We observed care and support being delivered in communal areas and viewed people's individual accommodation. We reviewed a range of documents and records including; four care records for people who used the service, eight medicine administration records (MARs), four records of staff employed at the home, meeting records, accidents and incident records, care record charts and a range of other quality audits and management records.

Inadequate

Is the service safe?

Our findings

Staff we spoke with told us they had received training in relation to safeguarding vulnerable adults and records confirmed the majority of staff had up to date training relating to this subject. On the first day of the inspection, we could not identify any immediate information displayed either around the home or in the main office area, to support both staff and people living at the home contact the local safeguarding team, if they had concerns. We asked the deputy manager whether such information was available and whether there was any easy read information for people living at the home to access. The deputy manager told us they had some somewhere and subsequently located a brief easy read document for another local authority. This was pinned to the notice board on the second day. This meant information to support people raising any safeguarding concerns was not immediately available.

The deputy manager on the first day and the regional manager on the second day told us there had been no safeguarding events at the home in the previous 12 months. We noted in some brief notes from a staff meeting in June 2016 that trainee worker had raised concerns about the care practices at the home that had the potential to be safeguarding matters. There was a note to say this needed to be "looked at." We asked the regional manager if she was aware if the matter had been addressed. She said, because she had only recently taken up post she was not immediately aware, but would ask the registered manager. She later emailed us to say the registered manager had told her he had looked into the issue but nothing had been recorded. This meant we could not be sure appropriate action had been taken in relation to potential safeguarding issues. It is a legal requirement for providers to have an effective system in place to investigate and act immediately upon being made aware of any allegation or evidence of abuse .

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 13. Safeguarding service users from abuse and improper treatment.

Risk assessments related to people's care were limited and it was not always possible to identify if the risks had been reviewed within an appropriate timescale. Where risks had been identified in relation to the delivery of care, then actions to reduce or mitigate the risk were often limited. For example, one person, who had a potential choking risk, had actions that stated, "Obtain new clear guidelines soft purred (sic) diet for now for safety." This information was not in line with the most resent guidance from the Speech and Language Therapy Service (SALT). The level of risk identified stated this should be reviewed at least three monthly. However, we could not identify this had been undertaken or in what timescale.

Another risk assessment, related to supporting a person with pressure care to maintain their skin integrity, had action to reduce the risk as, "Ensure personal care needs met offer pressure relief, use appropriate equipment. Nutritional diet." Again it was not possible to be clear this risk had been reviewed and revised. A third person had no risk assessment in relation to a potential choking risk, although a letter from the SALT team suggested that some foods or textures may cause a potential hazard. This meant risk assessments were not robust, did not always contain enough detail on actions staff should take and were not always reviewed in a timely manner.

There was no updated risk assessment related to the support people may require in the event of a fire, or personal emergency evacuation plan (PEEPs). The last available PEEPs we saw were dated 2014 and had not been updated since then, and did not include all the people currently residing at the home. Such plans should be regularly reviewed to ensure they are up to date and easily accessible for staff or emergency services to refer to quickly. We asked the regional manager if these were the most recent PEEPs available. Neither she nor the deputy manager were able to locate more up to date PEEPs and said they were not in the 'grab bag' that the home had ready to use in an emergency. The regional manager later confirmed in an email that the 2014 PEEPs were the most up to date available at the home. This meant people were potentially put at risk because up to date guidance and information was not available to staff or emergency professionals.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe Care and Treatment.

During both days of the inspection staff were available on the unit and were noted to be supporting people in daily tasks. The regional manager told us normal staffing was to have one nurse and three care workers on duty during the day and one nurse and two care workers on during the night. We noted there had been frequent use of agency staff in recent weeks. The regional manager told us this had been necessary because there had been a number of staff on long term absence recently. She said efforts were made to book the same agency staff to provide consistency and also nursing staff would sometime 'drop down' and undertake a care shift, in addition to their nursing shifts. Staff we spoke with told us that until recently the day time staffing had been one nurse and four care workers. They raised concerns that one person, who had recently been admitted to the home, required almost one-to-one support and had to be in line of sight at all times. We saw on the second day of the inspection this person was constantly accompanied by a member of staff. We asked if there were any dependency assessments used to determine the level of staff required. The regional and project manager were not immediately aware of any assessment tools, but after the inspection emailed us and said staffing at the home was linked to agreed contracts with the local authority. She said the person who required almost constant supervision had been allocated two hours a day dedicated time. She said the home had recently decided this was not enough support, although we saw the person had been at the home for around a month. This meant there was no clear link between people's assessed needs and staffing to ensure people's care and support could be appropriately and safely provided.

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

People living at the home were supported with their medicines. On the first day of the inspection we noted there were creams kept in people's rooms. We saw one of these creams was dated from 2014, although the instructions on the side of the container stated the contents should be discarded 30 days after opening. Other creams in bathrooms or toilet cupboards did not have people's name on or the names had rubbed of, meaning it was not clear which person the items were for. We also noted one person was prescribed thickener, to be added to their drinks to limit the risk of choking. On the first day of the inspection this thickener was left on the drinks trolley during meal times. This posed a risk because if swallowed, when not added to drinks, such thickeners can cause a choking hazard. We spoke with the registered manager about this and he told us it would be removed. On the second day of the inspection we noted these items had been removed and stored safely.

On the second day of the inspection we looked at people's medicine administration records (MARs). We found some issues related to the recording of medicines. For example, some people were prescribed "as required" medicines. "As required" medicines are those given only when needed, such as for pain relief. We

found that not all these types of medicines had a care plan detailing when they should be given and the actions staff should take. Additionally, some medicines had "as required" care plans and had clearly been given intermittently, but the main MAR information indicated they should be given regularly. Some signatures were overwritten on what appeared to be a "refused" (R) recorded symbol, making it unclear if the medicine had been given or when it had been given. We noted that many of the prescribed creams and lotions had the instructions, "as required" or "use as directed." We asked the nurse on duty whether there were more detailed instructions on the use of creams. They told us it was usually the nurses who assessed whether creams should be used and there were no other instructions. This meant there were no clear instructions on the use of creams and lotions. We noted there was some over stocking of certain medicines, meaning the ordering systems in place were not robust. For one person, who was prescribed thickener there were in excess of 40 tins of thickener stored in the clinic room, some dating back to April 2016. We spoke with the regional manager about this. She said she would review the medicines stock ordering system. This meant systems were not in pace to ensure medicines were managed safely and effectively.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe Care and Treatment.

Although not everyone living at the home was able to communicate with us verbally, those people we did speak with told us they felt safe living at the home. One person told us, "Yes, I do feel safe here." A range of safety checks were undertaken at the home. We saw copies of gas safety certificate, fixed electrical wiring safety certificate and Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) certificates for hoists and other lifting equipment. Regular checks were also undertaken on fire safely equipment, both by the home's handyman and outside contractors. The home had in place a Legionella risk assessment to say the water system was free from contamination and an asbestos risk assessment. This meant appropriate checks were in place to ensure equipment and the structure of the home was safe and well maintained.

We looked at personnel files for staff currently employed at the home. We saw an appropriate recruitment process had been followed, with at least two references requested, identity checks and Disclosure and Barring Service (DBS) checks undertaken. DBS reviews ensure staff working at the home have not been subject to any actions that would bar them from working with vulnerable people. Where any issues had been highlighted on a DBS check then consideration and an assessment of any potential risk had been made at interview. Staff were also subject to a period of probation, during which their suitability for the role was reviewed. We saw evidence of a final sign off of the probation period was undertaken. The regional manager told us all nurses working for the provider had their registrations checked on a monthly basis by the Human Resources department. All nurses are legally required to maintain an up to date registration with the Nursing and Midwifery Council to allow them to practice. This meant the provider had in place appropriate systems to recruit appropriately skilled and trained staff.

Overall we found the home to be clean and tidy. Bathrooms and toilet areas were well maintained and there were no unpleasant odours throughout the building. Some of the older furniture was stained and some light pull cords were of a material that could not be effectively cleaned. We spoke with the regional manager about this who said this would be looked at as part of future plans.

Inadequate

Is the service effective?

Our findings

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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

We asked the registered manager if people living at the home had been subject to a DoLS or an application for DoLS. The manager told us some people had DoLS in place. When we requested a list of all DoLS in place the registered manager told us that some people's DoLS had lapsed in April 2016. He said he had only recently applied to renew them. The registered manager told us this was his responsibility and he had not been on top of things in relation to monitoring DoLs at the home. This meant some people living at the home may have been detained without appropriate authorisation as applications or reassessments had not been undertaken to decide if DoLS orders still needed to be granted.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 13. Safeguarding service users from abuse and improper treatment.

Some people living at the home had fluctuating or limited capacity to make decisions for themselves. Where people are unable to make decisions for themselves and no Power of Attorney is in place to allow someone else to make decisions on their behalf, then the MCA prescribes that a best interests decision should be made. Best interests decisions should review people's capacity, look at a range of options in how best to support the person, consult with involved professionals and family members and finally reach an appropriate decision. We noted two people at the home were receiving their medicines covertly. Covert medicines are given to a person disguised in food or drink, because they may otherwise refuse them. We asked the registered manager and deputy manager if a best interests decision had been undertaken in relation to this. They were able to provide us with a care plan and advice from the local general practitioners about the use of covert medicines, but could not demonstrate a best interests discussion had taken place. We also saw that people used lap belts when in wheelchairs and bedrails to support them when resting. Although these devices were appropriate to keep people safe the MCA classifies these as forms of restraint and a best interests decision is required to support their use. The manager and deputy manager were unable to demonstrate these had taken place to comply with the MCA.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 11. Consent

During our inspection we spent time observing how people were being supported over meal times. A

number of people living at the home had been assessed as having a potential choking risk by the local Speech and Language Therapy (SALT) service. The SALT team had made recommendations for one person that they were to be supported with a moist fork mashable diet, should be encouraged to sit as upright as possible during meal times, with their head at a midline point and should be helped to remain as upright as possible for 30 minutes after the meal. We witnessed this person was sat in an easy chair and was almost bent double whilst the care worker was trying to support them. On the first day of the inspection staff were unsure about what diet the person should have and gave them a pureed diet, rather than a fork mashable diet. We overheard staff say to the home's cook, "Does (person's name) still have pureed food?" The cook replied to the comment, "I think so. Oh, I didn't know if it had changed. This is a concern." One the second day of the inspection we saw they were offering the person soup, which they could not take in any quantity because of their position. We raised concerns with the registered manager on the first day of the inspection and a further SALT referral had been made between the two days. However, we saw the person was still being supported in the same way on the second day. We observed this support with the regional manager on the second day, who agreed it was not appropriate. We looked at the care records of other people living at the home who required support with eating and drinking. We noted that the care plan details did not always reflect accurately the recommendations of the SALT professionals. We also saw that people's food and fluid charts, where there was concern about their food and fluid intake, were not completed contemporaneously, or by the people who had directly supported the person. This meant we could not be sure these records accurately reflected what people had eaten or drunk.

We looked at the home's training records, which were emailed to us by the regional manager. We saw several staff at the home had received training linked to supporting people with choking or swallowing risks, including the deputy manager, who was on duty on both days of the inspection. This meant the risk of choking for people living at the home was heightened because staff were not following professional advice on how to support the person with their meal. We have referred this matter to the local safeguarding adults team and asked the registered manager and regional manager to immediately review all care plans related to people's eating and drinking needs.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe Care and Treatment.

Staff told us they received a range of training and support in order to allow them to care for people at the home. Comments from staff included, "This is a good home compared to where I worked before. The organisation is good and train and support us well" and "(Provider) do a lot of training. Some staff are doing NVQs (National Vocational Qualifications)" Staff told us training was a mixture of face to face events and some on line training. We asked staff if they had received specialist training to help them support people whose behaviours could sometimes be described as challenging. Staff said they had not received any recent specific training. One staff member told us, "There has been a change in the type of residents we support. They can be more challenging at times. If staff do not get the training and the experience it can be difficult. Staff do need more training to support people." The regional manager showed us the training matrix for the home. We saw mandatory training, such as moving and handling, safeguarding adults and first aid was up to date. She said they were aware that more specialist training had not been kept up to date and MAPA training (Management of Actual or Potential Aggression) had been arranged for later that month. We asked to see the training records for all staff working at the home. These were subsequently emailed to us following the inspection. We saw particular training on non-violent interventions training had required updating in 2014, for the majority of staff. This meant staff had not received particular training that would help them support people living at the home.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation

18. Staffing.

Staff told us and records confirmed they had been subject to regular supervision sessions. Staff told us the provider had recently changed the system and had introduced a new supervision and appraisal system. Staff said they were able to discuss a range of issues in these sessions. Some staff had also been subject to a recent annual appraisal, although we could not find any recent documentation for other staff members. The regional manager told us annual appraisals had been slightly delayed due to the change in documentation. She said all annual appraisals were due to be completed by the end of the month.

There was evidence in people's files that they had access to a range of health professionals including medical practitioners, physiotherapists, and speech and language therapists. People also had a hospital passport in the front of their files which gave details of people's needs if they needed to be admitted on an urgent basis at any times. There were copies of letters detailing the action the home should take to support people with their health. However, with regard to SALT advice we found this was not always followed.

The home was situated in the middle of a now disused hospital site and was the only functioning building on the site. The registered manager told us plans were in place to relocate the service to other possible locations in the area, although no final decision had been made. He said that in the mean time they were trying to maintain the service. Staff told us the current location made it difficult to fully integrate people into the community and that any trips out had to be in the minibus or taxi. Whilst people's personal rooms were highly personalised with decorations, photographs, lights and in one case a fish tank, we found the communal areas were in need of refreshing. The communal lounge area and the dining room were largely empty and lacking a homely feel. Tables in the dining room were covered with plastic tablecloths and there were no adornments on the tables. On the first day of the inspection all cushions in the lounge area had been piled into a corner and the atmosphere was stark. Not all lights in the lounge and dining area were working, although this had been addressed by the second day of the inspection.

Requires Improvement

Is the service caring?

Our findings

During our inspection we spent time observing how people were cared for and how staff interacted with people during the delivery of care. We spent time on the first day of the inspection observing mealtimes at the home. We noted one care worker brought a person into the dining room in a chair and did not refer to the person by their preferred name but asked other staff, "What do you want me to do with this one?" We noted one person we had previously seen around the home was not in the dining room and asked staff if they would be joining the group for lunch. The same care worker then openly swore and said the particular person had been forgotten. During the lunch time we also noted staff did not always concentrate on the people they were supporting but tended to talk to one another over people's heads and did not always try and involve them in conversations. We spoke with the manager and deputy manager about this incident. They told us they were shocked by the behaviour and would immediately look into the matter. This meant people's dignity was not respected because staff actions observed did not support this.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 10. Dignity and Respect.

We noted that in other respects people's privacy and dignity were supported. We saw that when personal care was being delivered staff ensured people's doors were closed. In one instance staff waited outside a person's room whilst they were being supported until they were required to help move them, thus reducing the number of people immediately involved in intimate care.

A relative told us they did feel involved in their relation's care. They said they visited regularly and staff asked them about things or they could question staff. We noted three relatives' meetings had been planned for the year, but could find no minutes from these meetings. We asked the regional manager about the meetings. She said that as far as she was aware the meetings had not taken place. She said the lack of regular meetings was something she had identified as a deficit at the home and she was looking to address. This meant there was no formal system to actively involve relatives in the running of the home or to receive feedback about the service.

Some people had picture boards or picture cards to help them make choices. The cook told us she would take time to go round people and ask them what they wanted to eat, and used the picture cards as a prompt to involve people in making a choice. We asked the cook whether, when people first came to live at the home, she asked people about their particular likes and dislikes for food, or, if they could not communicate this directly, whether she asked relatives for any pointers. The cook said she didn't automatically do this, but tended just to use the picture cards on a daily basis.

People we spoke with told us they liked the staff and they felt they looked after them well. At times during the inspection we saw staff did take time to speak with people, tried to involve them in conversations and tried to support them to been independent through encouraging them to do things for themselves. They asked them if they wanted more juice to drink, suggested they may want help to tidy their hair and asked one person if they were cold and whether they wanted a blanket to cover them.

Staff we spoke with had a good understanding of people and their needs. They were able to talk appropriately about people's likes and dislikes and approaches that best suited them. Staff were able to talk knowledgably about the signs they would look for to indicate a person was possibly going to have an epileptic seizure, or the facial and non-verbal expressions which indicated another person may be in pain. Staff said they would like to give people more time and help them develop. One staff member told us, "It's more than just keeping them safe; it's valuing them."

Requires Improvement

Is the service responsive?

Our findings

People had care plans to detail the support they required in their day to day lives. Some of this information provided good detail for staff to follow. However, we found in other care plans the information provided was not always appropriate or did not reflect the advice of professionals. For example, one person's care plan related to their support with food and fluids stated that the person did not have any swallowing or choking problems, although a letter from the SALT team stated they were at risk of aspiration during meals. We asked the deputy manager about this. She said the person was no longer supported by the SALT team and the person no longer had a swallowing problem, but we could find no information from the SALT team stating this. Another person's care plan detailed how staff should support them if they went into an episode of frequent epileptic seizures. If this occurred the care plans said the person may be given a particular medicine. However, the plan also stated the person should be hoisted onto the bed to receive this medication. We asked the deputy manager if she would consider hoisting a person who was having seizures. The manager said she would not. She said she had queried this advice, which had come from a moving and handling advisory session, rather than a full assessment of the person's needs. She said the person was due to be seen by a general practitioner next week to change the medicines to a more appropriate type.

A third person had only recently come to live at the home. They had a plan to assist them with their continence needs. The person was prescribed an incontinence product to help them with this matter and maintain their dignity. However, we noted a copy of the care plan from the person's previous home was also in their care file. This plan was dated 7 October 2016 and stated the previous home had instigated a programme of regular toileting for the person. This regime had reduced the instances of the person suffering from incontinence. We found this information had not been incorporated into the person's current care plan. This meant people's care plans did not always contain appropriate information or reflect information and advice from professionals or other services.

Care plans were reviewed on a monthly basis. However, these reviews were not detailed and it was not clear the risks associated with care delivery were properly and thoroughly reviewed at the same time. There was no clear evidence that consideration had been given to any progress or difficulties the person may have experienced over the previous month. Where plans had been reviewed they often contained limited phrases such as, "Update to SALT." In one person's care plan, who required support with a specific medical condition with a high infection control risk, there had been no reviews for three months out of nine in 2016. One review indicated that a change needed to be made to their care plans, but there was no indication what this should be. In another person's care plan the risk assessment had another person's name written in it, which was then scribbled out and the second person's name hand written in. Reviews contained no obvious revision of risk levels. This meant we could not be sure people's care had been effectively reviewed or that where reviews had taken place any changes to care had been effectively made to the plan.

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

Staff told us the home did have an activities worker, although they were off duty on both days of the

inspection. They told us the activities worker took people out into the community for visits to local places and events and undertook activities in the home. They said they would sometimes accompany the activities worker to help support people, but would not normally carry out such activities themselves. One person we spoke with told us they went out three times per week and enjoyed these trips away from the home. On the first day of the inspection we were shown into a large room that was currently being used for storage. The registered manager told us this had previously been a sensory room to support people with sensory deficits through the use of light and sound. He told us the room was to be cleared and brought back into use and a container had recently arrived on site to store the equipment from the room. On the second day of the inspection the room was clearer, although equipment was still stored in some corners. Staff told us the room had been out of commission for a year or more and said there were people living at the home who would benefit from spending time in the room and experiencing the sensory stimulations provided. They said that whilst the room had been cleared there was still work to be carried out to make it functional. We were shown copies of a review document by the provider's quality team, who had visited the home in September 2015. We saw one of the action points in this document was for the registered manager to, "ensure the clutter within the sensory room is appropriately dealt with and a more acceptable use for the room is put in place." This meant action had not been taken to address the matter for over 12 months meaning people were unable to access this facility, which may have proved beneficial to their well-being.

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

Care plans contained a document detailing people's personal details and capturing issues that were important to the individual or an "All about me" document highlighting personal preferences. The documents emphasised what people liked about the person, what their aspirations were and what was important to the person. For example, one person's individual plan highlighted that others liked their sense of humour and that they tried to undertake tasks independently. They aspired to have regular contact with their family members and wanted a weekend activity break in the future. It was important for them to be able to choose their own clothes as much as possible and to ensure they had regular pain relief, as required. This meant care plans contained some information about the person as an individual.

The regional manager told us there had been no formal complaints in the last 12 months. Information on raising a concern was available on a notice board in the home. A relative told us they had not made any complaints, but were aware of how to if they wanted to raise any concerns. The regional manager told us there had been three formal compliments sent to the home in the last 12 months, all thanking the home for the standard of the care delivered. We saw details of these compliments, which were all from family members, were recorded on the provider electronic information system. This meant the provider had in place a system to deal with complaints and compliments.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in place and our records showed he had been formally registered with the Care Quality Commission (CQC) since October 2010. A registered manager is a person who has registered with the CQC 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. We were supported on the first day of the inspection by the registered manager and the deputy manager. On the second day of the inspection were supported by the regional manager and one of the provider's project managers.

Providers are required by law to notify the CQC of significant events at homes, including: deaths, serious injuries, the granting of DoLS and any safeguarding incidents. We noted there had been at least five DoLS that had been granted and four that had lapsed within the last two years. Our records showed none of these events had been notified to the CQC, as legally required. The registered manager agreed this had been an oversight on his part.

This was a breach of the Health and Social Care Act 2008 (Registration) Regulations 2014 Regulation 18. Notifications

The regional manager told us the registered manager carried out a number of checks at the home including regular health and safety checks, audits on medicines and monthly reviews of care plans. We saw copies of the health and safety audits and medicines checks. The monthly care plan reviews were those previously noted to be poorly completed and recorded. The regional manager also showed us a self-assessment document completed by the registered manager in January 2016. We noted a number of items had been identified as green (completed), but were not in place. For example, the self-assessment stated all required notifications to the CQC had taken place. We asked the regional manager if this self-assessment was reviewed. The regional manager told us the previous regional manager, who had been in post for approximately 10 months had not carried out any checks at the home and therefore there were no regional manager reports or check available. She also told us the provider's quality team had visited the home in September 2015 and produced a report with action points for the manager to complete. We asked how this was followed up. The regional manager stated this had not been followed up by the team, to ensure their recommendations had been complied with. This meant checks on the delivery of care and the effective management of the home had not been undertaken and there had been a lack of senior management oversight.

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

We saw a number of people living at the home were supported through the use of food and fluid records, because there were concerns about their food and fluid intake. On the second day of the inspection, having observed the lunchtime meal, at around 2.15pm, we asked the nurse on the unit for sight of the food and fluid charts for that day. The nurse said he had not completed them at the present time. He told us that care

staff supported people with food and fluids and then advised him what had been taken. He said he made an initial note on a handover document and then completed the food and fluid charts at a later time. A care worker later told us that the nurse would complete the food and fluid charts and they would sign them. We looked at the food and fluid charts for previous days. We saw the amounts recorded were round figures such as 200mls or 150mls. The regional manager, who had spent time observing lunchtime with us, agreed the records were unlikely to be accurate. This meant records with regard to food and fluid were not completed contemporaneously and were completed by a member of staff who was not directly involved in the care delivery.

One person's care plan indicated that because of health difficulties they were at risk of losing weight. Their care plan indicated they should be weighed weekly to monitor their weight. We looked at the weight record in the home's observation folder. We saw there were gaps in the recording of the person's weight and that only monthly records had been kept. There were no weight recordings for March, April and May 2016 and a further gap in August and September 2016. This meant records important in the monitoring of care delivery and people's wellbeing were not up to date.

Records at the home were disparate and maintained over several folders. The registered manager told us the provider was currently changing care documentation and that some files were in the new style format and some in the old style format. The registered manager was often unsure about which files had been updated and where information was stored; whether this was in the new file or the old filing system. In addition personal information was often stored in other files. For example, people's weights were recorded in an observations file, separate to their main care files and plans. This meant important information about people's care was not always immediately available.

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

In addition to the lack of meetings with relatives we saw there were limited meetings with staff members. We noted the last full staff meeting for which notes were available was 2 June 2016, with the previous meeting dated as February 2016, and the last qualified staff meeting had taken place on13 June 2016. We saw in one staff member's supervision records they had raised the need for more staff meetings in April 2016. The regional manager told us the need for more staff meetings had been highlighted as an issue to be addressed. This meant there were limited opportunities for staff to actively contribute to the running of the home.

Staff told us they enjoyed their jobs and supporting people. They said staff morale was currently quite low, due to some recent staffing issues.

The regional manager told us she had only recently taken up post. She said following the first day of the inspection she had reviewed the operation of the home and identified issues that needed addressing. She said she had already started to put together an action plan, detailing some issues identified on the first day of the inspection and other items that she herself had noted. She gave us a copy of the action plan. We saw a range of matters, including direct care delivery, documentation, care plan and risk assessment reviews, medication and meetings had been identified as needing addressing. Since the inspection the regional manager has kept us up to date on progress against this action plan.