Scope

The Hollies

Inspection report

1-3 The Hollies
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Date of inspection visit: 30 October, 3 and 9 November 2015.
Date of publication: 16/02/2016

Ratings

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

Overall summary

This inspection took place on the 30 October, 3 and 9 November 2015. The inspection was unannounced.

1– 3 The Hollies is a purpose built care home comprising of three separate bungalows providing personal care and accommodation for up to nine people who have a physical disability. Each bungalow has three bedrooms, separate lounge, kitchen dining room and bathroom and toilet. The premises are equipped and adapted to meet the needs of the people who live at the home. There is level access to each property and tracked ceiling hoists have been installed where required. Each bungalow has its own garden area and off road parking is available for several vehicles. Staff and the people who use the service have the use of a small office which is located adjacent to bungalow 3.The home is located in a residential area of Runcorn and is within easy access of the local amenities.

On the first day of our inspection there were 9 people living in the home, one of whom was away on holiday.

The home has a registered manager. A registered manager is a person who has registered with the Care

Summary of findings

Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we carried out our last inspection of the home in June 2014 we found that the provider was meeting all the requirements for a service of this type.

Whilst we found that people were provided with care that was person centred, sensitive and compassionate the home was not always being managed effectively. There were times when there were insufficient numbers of staff on duty, to provide a safe service to the people who lived in the home.

Although most people told us they felt safe, we found that the service did not always operate robust safeguarding procedures and staff had not always taken effective action to protect vulnerable people from abuse and neglect.

We also found management were not learning from past events, or taking effective corrective action to improve the service.

We identified breaches of the relevant regulations in respect of the need for consent, safe care and treatment, nutrition, good governance, and staffing. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Most of the people told us that they felt safe and the staff we spoke with were aware of how to recognise, and of their responsibilities to report, signs of abuse. However, allegations of abuse had not been acted upon and risks were not always managed effectively. The home benefited from a well-established staff team but there were occasions when there had been inadequate numbers of staff on duty.

Recruitment records demonstrated there were systems in place to help ensure staff employed at the home, were suitable to work with vulnerable people.

Is the service effective?

Requires improvement

The service was not consistently effective.

People told us that they were well cared and the staff team presented as caring and committed to the provision of person centred and compassionate care. However, there were gaps in staff's knowledge and skills which could put the people who lived at the home at risk of their needs not being met.

People were involved in planning their care but managers and staff did not always act in accordance with the Mental Capacity Act 2005 to ensure people received the right level of support with their decision making.

Is the service caring?

Good

The service was caring.

The established staff team knew people well and provided support discreetly and with compassion.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Requires improvement

The service was not always responsive.

Person centred care planning, monitoring and review, had been introduced to the home in recent years. However, the person centred care planning programme had not been implemented effectively. Staff did not always understand their roles and responsibilities and this and staff shortages had impacted on the staff teams ability to meet peoples' needs in accordance with agreed plans.

Summary of findings

Staff had developed effective means of communicating with all the people who lived at the home. The use of assistive technology was being explored and in some instances taken advantage of, to ensure people could express their views.

Is the service well-led?

Requires improvement 

The home was not always well-led.

Systems and processes established to ensure compliance with the regulations had not been used effectively to identify and solve problems and ensure the welfare of the people who lived at the home. Managers and staff were not routinely analysing accidents and incidents so opportunities to learn from past events and near misses were being lost.

The Hollies

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.

We carried out an unannounced inspection on the 30 October, and visited again announced on 3 and 9 November 2015. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information the Care Quality Commission already held about the home. We contacted the local authority commissioning teams before and after the inspection and they shared their current knowledge about the home. During the inspection we spoke with all nine of the people who lived at the home. We talked with 11 members of staff including eight members of the care staff team, the registered manager, team leader and area manager. We looked at three care and support plans as well as other records and audit documents. We looked around the building including, with the permission of people who used the service, some bedrooms.

Inadequate

Is the service safe?

Our findings

The atmosphere in the home was welcoming and sociable. Staff were kind and caring in their approach and we saw that people were comfortable and at ease in the home's environment. We could see that the staff were sensitive to the needs and rights of the people who lived at the home. An example of this was the way they supported them to take the lead in welcoming the inspector and showing them around the premises. Throughout the course of the inspection staff always deferred to the people who lived at the home, taking a step back when appropriate to empower each individual to answer the inspector's questions themselves. We saw smiles on the faces of the people who lived at the home and it was clear that they were confident and forthcoming in the home's environment.

Most of the people living at the home told us, or indicated that they had good relationships with all the staff. However, two people told us that they did not always like the way some of the staff behaved. One person who was prepared to elaborate on this told us that they did not feel safe and described incidents which amounted to allegations of abuse. They told us that they had told staff about their concerns but nothing had been done to address them and an unsatisfactory situation had been allowed to continue.

We took action during the course of the inspection to ensure that these allegations of abuse were reported to the local authority and the police without any further delay.

We shared our concerns with the registered manager who confirmed that a staff member had been aware of these allegations since March 2015 but had not reported them to the team leader or registered manager. It transpired that they were reluctant to report allegations or abuse because they were afraid of reprisals from other staff members. We spoke with four staff members about adult safeguarding procedures. They told us that they had training on adult protection and knew how to recognise abuse and were aware of their responsibilities to report signs of abuse but there were gaps in their knowledge. They were unaware as to the protection afforded those who "blow the whistle" under the law and they did not know who they could report to outside of the organisation. "Blowing the whistle" is a commonly used term which is used to describe when people speak out about poor practice or abuse. None of the staff spoken with about safeguarding procedures were aware that the local authority took the lead on safeguarding vulnerable adults or that they could report allegations of abuse and retain anonymity. They did not have ready access to the local authority's contact details and although they told us they were aware of the home's "whistle blowing policy" they did not know that whistle-blowers honestly reporting evidence or suspicion of abuse were protected under the provisions of the Public Interest Disclosure Act 1998.

We asked the manager for a copy of the home's "Whistleblowing policy" and we were given a sensitively written guidance note titled "Speak up on Bad practice". This outlined the provider's "Speak up Policy" and the associated "Speak up service" which was designed to help and support staff to speak out on bad practice. The document identifies that staff are encouraged to raise concerns with their line manager but also have the alternative of reporting to the 'Speak up service' via a dedicated phone line and email if they are uncomfortable addressing issues with their manager. This document mentioned the Public Interest Disclosure Act 1998 but did not outline the protection this act affords those who "blow the whistle" in the best interest of vulnerable people. It did not outline the duties and responsibilities of the local safeguarding agency or state how they may be contacted.

We checked the medicines and medication administration records for three people. We spoke with the manager of the home, two of the support staff and the team leader with responsibility for medicines. We found that medicines were given as prescribed by the doctor, with the exception of a number of anomalies regarding the administration of medicines given on an 'as and when required' basis (known as PRN). A person who was taking a medicine for pain on a PRN basis told us that they had been given paracetamol that morning and had been told to take it. We asked whether they had asked for the medicine, had they been experiencing any pain. They told us no and said again that they had just been given it to take. We looked at the person's Medicine Administration Record (MAR) chart and could see that paracetamol had been administered that morning, but there was no record as to why it was given or how many tablets were given. The MAR charts included a form entitled "Carers Notes" which would be useful for recording why PRN medicines were administered, but these had not been completed. We looked in the person's diary where staff make routine notes each day as to the well-being of the individual. There was no record of the

medicine being given and no indication why it should have been given. In fact the note recorded: "in lovely mood all day" there was no indication that the person was in any sort of pain. Because the number of tablets given at any one time was not recorded it was impossible to make an effective stock check. Therefore staff were unable to demonstrate that the medicines had been administered as the doctor prescribed.

Another person was also prescribed paracetamol on a PRN basis. They had two boxes of the medicine one dated 27/04/15 and the other dated 17/08/15. Each box indicated that initially they each contained 60 tablets. The manager checked the records and found that there was no record of this medicine being administered to this person dating as far back as far as beginning of April 2015. Therefore there should have been 120 tablets in stock. However the box dated 17/08/15 contained 22 tablets and the other box dated 27/04/15 contained 74 tablets 96 tablets in all indicating 24 tablets were missing and unaccounted for.

The home had four medicine rounds. The timing for the medicines rounds was four hours apart for breakfast, lunch, dinner and night time. When we visited, there was no time documented for when paracetamol had been given and therefore it would be difficult to ensure a minimum of four hours' time interval had passed between paracetamol doses with the current timings on the MAR chart.

The manager told us medicines audits should be completed on a monthly basis, according to the provider's policies and procedures, but confirmed that a PRN medicines audit had not been completed since May 2015. This meant that errors in the administration and recording of medicines had not been identified, investigated or rectified.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was not ensuring the proper and safe management of medicines.

In the afternoon on the first day of our inspection we could see that there was an insufficient number of support/care staff on duty to meet the needs of the people who lived at the home. We could see that the two staff on duty endeavoured to meet people's needs but they could not be in two places at once. One staff member located themselves in the bungalow where they believed people presented with the highest level of need and the other worked between two bungalows. On one occasion we saw a staff member hurrying from one bungalow to another with a hot meal they had cooked for a person who lived in the other bungalow. Cooking meals for rather than with the person is contrary to the aims and objectives of the home. The meal was uncovered and exposed to the elements. Shortly after in another bungalow, we observed a person in their bedroom eating their meal unsupervised. A risk assessment and eating and drinking guidelines provided by the person's speech and language therapist showed that they were at risk of choking and must be supervised at all times when eating their meals. The eating and drinking guidelines stipulated that "this advice must be adhered to by all to minimise the risk of choking". This person did not have capacity to summon assistance or capability to use the 'nurse call' alarm which was out of their reach. Failure to follow the risk assessment and eating and drinking guidelines put the person at unnecessary and unacceptable risk of harm.

This is a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered persons were not doing all that is reasonably practicable to mitigate risks to the health and welfare of the people who lived at the home.

When we started our unannounced inspection there were three members of staff on duty one working in each bungalow. We spoke with five staff about staffing levels. They told us that they could cope and meet the health and social care needs of the people who lived at the home with a minimum of three support/care staff, preferably four but when there was only two staff on duty they were unable to ensure that people's needs were met.

The staff rota showed that only two members of staff had been rostered on duty in the afternoon and evening of the first day of the inspection. Staff were unable to say why only two staff were rostered on duty in the afternoon and evening because they had not been informed of the reason. Staff told us that they had not been given any further guidance as to how they should cope with only two staff on duty or how they could mitigate risks presented to the people who lived at the home. There was no direct managerial support to assist them or provide supervision. The team leader was on annual leave as was the registered manager. Staff told us that another team leader who was based at the sister home Harbour Close was available

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should they need managerial support. However, when staff tried to contact them in an emergency later in the afternoon they found that team leader was also on a day off.

Staff told us that there had been significant staff shortages in August and September due to staff holidays and sickness. Staff rotas showed that there had been nine mornings and 13 afternoons when at times there had only been two staff on duty in August and September 2015. We could see from people's daily care records that they had been prevented from accessing the community as regularly as they would wish because of staff shortages. For example the records for one person who liked to get out and about regularly showed no activities for August 2015. An entry in their activities records for September read: "X did not go out every week due to staff sickness and holidays" and only one activity was recorded. We spoke with this person's key worker and they told us that goals and activities agreed at this person's person centred planning (PCP) meeting had not been met because of staff shortages.

Another person's activity records showed that they had only been out of the house twice in October 2015 and again goals agreed at their PCP had not been met. Their key worker told us that staff shortages limited people's opportunities. They said they need a minimum of 3 staff to meet people's needs in the house and at least four staff to offer them opportunities in the community. The manager acknowledged that there had been staff shortages in August and September and told us that staff holidays and sickness needed to be managed better.

As part of the inspection we spoke with a District Nurse who provided community based nursing care to the people who live at the home. They told us that they had concerns about staffing levels as they often had difficulty getting staff to assist them when required. They told us that on one occasion they found that a vulnerable person was left on their own in their bungalow and were concerned about their welfare.

The issues outlined above comprise a breach of Regulation 18 (1) (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered persons did not always deploy sufficient numbers of suitably qualified, skilled and experienced staff to meet the assessed needs of the people who lived at the home.

We could see that the people who lived at the home were supported to live with an element of risk in the interests of leading a fulfilled life style. Personal care records showed that some potential hazards in each person's daily lives had been identified, recorded and risk assessed. However, there was significant room for improvement. We saw that the garden gate which joined the garden of bungalow two and three presented significant hazards to the people who lived in bungalow two. The gate led to five concrete steps and a steep drop to bungalow three. Some of people who lived at bungalow two used electric wheelchairs and on three separate occasions we found this gate wedged open, even after we had pointed the potential hazard out to staff. There was no record of the potential hazard being identified or managed. The manager confirmed that the hazards presented by the five concrete steps had not been risk assessed.

Accident records showed that a person had been injured when they were exiting a taxi as they were assisted by the taxi driver down a ramp. The records showed that the taxi driver had lost control manoeuvring down the ramp and the person had fallen out of their wheelchair. This particular activity was risk assessed but records showed that the accident had not been analysed and the risk assessment had not been reviewed in the light of the incident in order to mitigate risks to the person.

This is a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered persons were not consistently assessing the risks to the health and safety of people receiving care or treatment and where not doing all that is reasonably practicable to mitigate such risks.

We looked at the recruitment files for the two most recently appointed staff members to check that effective recruitment procedures had been completed. We found that the appropriate checks had been undertaken to help to minimise the risk of employing unsuitable people to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions to help prevent unsuitable people from working with vulnerable groups.

We saw from these files that the home required potential employees to complete an application form from which

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their employment history could be checked. References had been taken up in order to help verify this. Each file held a photograph of the employee as well as suitable proof of identity.

There was also confirmation within the recruitment files we looked at that the employees had completed a suitable induction training programme when they had started work at the home.

We found that the people living in the home had an "Individual Escape Plan" which provided personalised guidance on action to be taken in the event of a fire to ensure the person's safety and well-being. This was good practice and would be used if the home had to be evacuated in an emergency such as a fire.

We recommend that staff are given written guidance on the role of the local authority in relation to safeguarding vulnerable people, including methods of reporting abuse and contact details. The protection afforded those who "blow the whistle" in the best interests of the protection of vulnerable people under the provisions of the Public Interest Disclosure Act 1998 (commonly known as the "whistleblowers act") should be included in the written guidance.

Requires improvement

Is the service effective?

Our findings

Most people spoken with during the inspection told us or indicated that their needs were met. One person told they had concerns about the way had been treated on occasion but in the main they were happy living at the home. People told us that they lived in a caring environment that was designed specially to meet their needs and promote their independence and we could see this suited them all. One person told us that they were very happy living at the home and two others told us that they loved it. Some of the people had difficulty verbalising but were all good at communicating what they were happy or unhappy with. There were lots of smiles and spontaneous laugher. We could see that they had positive relationships with the staff and there was a sense of mutual respect and regard between both groups of people. It was clear to us that the people who lived at the Hollies regarded it as their home and staff reinforced this belief in the way they supported people and empowered them to take the lead in all interactions with the inspector. For example it was one of the people who lived at the home who was first to offer and make the inspector a cup of tea and another told the inspector "I will show you around" and proceeded to do so.

Many of the staff had worked at the home in excess of 10 years and it was clear they knew the people who lived at the home well. One member of staff told us that they had come to regard the people who lived at the home as they would a family member and other staff expressed similar sentiments. However some staff were unclear about some aspects of care and there was evidence of confusion and misunderstanding as to how people's needs were to be met.

One staff member told us that two of the people who lived at the home had been prescribed rescue medication to be used in the case of a severe epileptic seizure. Other evidence contradicted that information. We spoke with the key worker for one of the two people who had epilepsy and they told us that rescue medication had not been prescribed for a number of years. Instead staff were required to respond to the person experiencing a sever seizure by calling an ambulance if the seizure lasted any more than two minutes. When we looked at this person's care file and we found that it did not reflect this advice and guidance. There was no care plan for epilepsy but there was a risk assessment. This actually recorded that an ambulance should be called if their seizure lasted 10 minutes. We asked the team leader whether this care plan reflected clinical advice. The team leader told us that the care plan was wrong and staff were expected to call an ambulance if the seizure lasted any longer than five minutes, otherwise the person would be at risk of harm.

We looked at this person's "Epileptic Seizure Record Chart". We could see that when the person had suffered seizures the staff had not responded appropriately, in that they did not call for an ambulance or seek any medical attention for any of the incidents. We saw that at one point the person had been admitted to hospital following a major seizure but the records showed that the risk assessment had not been reviewed in the light of these incidents. We made further enquiries and found that the incidents had not been analysed by the registered manager or team leader. They had not queried the delay in calling for medical assistance and they had not identified the error in the care plan, which had put the person at risk of severe harm. They had not given consideration as to how the risk of harm could be minimised in the future such as the use of assistive technology to activate the alarm automatically should the person have another seizure during the night.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered persons were not consistently assessing the risks to the health and safety of people receiving care or treatment and where not doing all that is reasonably practicable to mitigate such risks.

We looked at how people's dietary needs were assessed and monitored. We found that one person was prescribed medication by their consultant to relieve constipation because it had been found that their other medical problems were exacerbated when they were constipated. There was however, no evidence that any consideration had been given to the person's diet. There was no fresh fruit or vegetables available in the person's home at the time of the inspection and although there was frozen vegetables in the fridge it was not clear as to whether staff were promoting a balanced and healthy diet.

We looked at the records for the person's dietary intake for a number of weeks and found that they had only been offered two portions of fresh fruit or vegetables one week. There were no records available for the following week, and

only one portion of fruit or vegetables was recorded in the next consecutive week. There was no care plan for this person concerning nutrition and no arrangements had been made to promote a healthy and nutritious diet.

The manager told us that the dietary intake records were checked to ensure there were no gaps in recording but there was no assessment as to whether the person was having a nutritious and healthy diet.

We looked at other people's dietary intake records and found again an absence of fruit and vegetables in their diet.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs. The registered persons were not always providing the people who lived at the home with healthy and nutritious food suitable to sustain life and good health.

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.

Staff told us that one person who lived at the home was subject to a DoLS authorisation but they were unclear as to what this meant in real terms. They told us that the person had capacity to make decisions and suggested that the DoLS was about other decisions such as going to hospital and accepting medical treatment, which was not the case. Records indicated that the DoLS was in place regarding the person living at the home under constant supervision and being unable to leave the home unsupervised but not being able to give informed consent to this deprivation of liberty.

We checked the records and could see that appropriate documentation was in place and that provider was complying with the conditions applied to this authorisation. However, it was also clear from records, information provided by managers and staff that the registered person's had not always acted in accordance with MCA. For example there was no mental capacity assessment in place to support why the application for the DolS was made. There were no mental capacity assessments to support other decisions which had been made by staff such as where to go on holiday, spending money and giving consent to receiving medication. We could see that staff always endeavoured to include people as far as they were able when making decisions about their daily lives but some decisions required the support of a mental capacity assessment.

The MCA assessment is designed to ensure that people get the right type of support to assist them with their decision making. It is also necessary in some circumstances to make a record where a best interest decision is made on behalf of the person. This is to ensure that managers and staff comply with the MCA and demonstrate that decisions are always made in the person's best interest.

Training records showed that almost all the staff had received training on the mental capacity act in December 2014 but we could see that there were gaps in their knowledge and as a consequence they had not always acted in accordance with the MCA code of practice when helping people with their decision making. The registered manager and the team leader told us that they did not know and had not been shown how to carry out a mental capacity assessment or how to construct and record a best interest decision process. They were unaware of the MCA 2015 code of practice.

We looked at the content of the training which staff had been given on the MCA and could see that they had not been introduced to the code of practice and had not been shown how to carry out a mental capacity assessment or make and record a best interest decision process.

The above comprises a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In providing care and treatment of service users the registered person's and staff did not act in accordance with the Mental Capacity Act 2005.

Requires improvement

Is the service effective?

The provider had their own induction training programme that was designed to ensure any new staff members had the skills they needed to do their jobs effectively and competently. We looked at the induction records for the most recently appointed staff member and saw that it was based upon the Skills for Care Common Induction Standards, a nationally recognised and accredited system for inducting new care staff. The registered manager told us that the new induction training package had been revised to incorporate the new Care Certificate. This is a new nationally recognised qualification which supersedes the common induction standards. It is an identified set of standards that health and social care workers should adhere to in their daily working life. It includes topics vital to each member of the workforce such as safeguarding adults, basic life support, health and safety, communication, person centred care, and equality and diversity.

All staff spoken with during the inspection told us that they were well supported and staff morale was good. They told us that they had benefitted from training in a range of relevant topics including safeguarding vulnerable adults, fire safety and night evacuation, moving and handling - customer handling, food and nutrition/hydration, emergency first aid, and medication. The homes training planner showed that future training was planned on food and nutrition/hydration, infection control, data protection/ record keeping, equality and diversity and epilepsy. Records showed that staff supervision meetings were offered on a regular basis and all staff benefitted from a personal development review at the end of each year. The manager told us that staff training and skills on safeguarding and nutrition will be reviewed as part of an action plan to improve the service in the light of issues identified on this inspection.

Good

Is the service caring?

Our findings

Throughout the course of our inspection we were impressed with the way staff responded to people's moods, demeanours, physical and emotional needs. It was clear that all the staff observed and spoken with knew each individual's likes, dislikes and personal preferences well. There were smiles, laughter, hugs and expressions of affection, cheery hellos and good byes which made for an extremely pleasant and welcoming atmosphere.

Staff had received training in the delivery of person centred care and we could see that this was having a positive impact. One of the people who lived at the home said with a broad smile: "we get the very best care here I get what I need, I get and what I want. I love girly things, look at my nails, and the staff know it, I have bath bombs in my bath and I come out smelling gorgeous". They added that one of the things which was most important to them was "feeling I belong". When asked for an example of this they said: "I love the staff and one of them brings their daughter in with her baby to see me and say hello." Other people made positive comments about the home or indicated that they were comfortable and at ease in the home's environment.

We could see that staff respected each person's personal preferences and promoted positive choice. People rose and retired at a time that suited them, chose what they wanted to eat and where they wanted to eat it. Staff always knocked on people's bedroom doors and waited to be invited in before opening the door.

As part of this inspection we spoke with the district nurses who provided community based nursing care for the people who lived at the home from time to time. They told us that the staff cooperated with them and acted on their advice and recommendations to ensure each person's health care needs were met.

The premises, although one care home, is actually three separate bungalows which are not joined by a corridor. We observed staff walking through one bungalow out through the patio doors and in the through the patio doors of the next bungalow to get to the office. Whilst staff routinely acknowledged people and usually sought their permission this practice appeared to detract from the otherwise purely domestic nature of each bungalow. The manager told us that staff were expected to use the front door of each bungalow and took immediate action to ensure that this good practice was reinstated.

We saw that the people living in each bungalow looked clean and well-presented and were dressed appropriately for the weather on the day and in accordance with their characters and personal preferences.

The quality of décor, furnishings and fittings provided people with a homely and comfortable environment to live in. The bedrooms seen during the visit were all personalised, comfortable, well-furnished, suitably equipped and contained items belonging to the person. A married couple had lived at the home for a number of years and in that time had requested that alterations be made to the accommodation to meet their needs and personal preferences. The manager told us that arrangements were being made with the housing association which owns the premises to secure the required alterations.

None of the people living at the home were considered to be nearing end of life or of an age or condition where such consideration would be necessary. However, the manager told us that they had engaged with a local hospice to implement the 'Six Steps Care Home Programme'. This is a framework for supporting people to live and die well which can equip nurses and care staff to recognise end of life situations and manage them more effectively, working in partnership with the individuals, their families and other organisations to deliver the best quality of care possible. The manager advised us that the home had been working through this process since early 2015 and further training sessions where being organised.

The provider had developed a range of information, including a service user guide for the people living in the home. This gave people detailed information on such topics as medicine arrangements, telephones, meals, complaints and the services provided.

We saw that personal information about people was stored securely which meant that they could be sure that information about them was kept confidentially.

Requires improvement

Is the service responsive?

Our findings

The atmosphere in the home throughout our inspection was relaxed and sociable.

All the people who were able to communicate verbally, told us that they were aware of their care plan and support plans including one person who made a specific request to discuss them with us. Those who had difficulty expressing their views verbally were able to express their needs in other ways and were able to make their personal preferences known. Most of the staff had worked at the home in excess of ten years and in that time they had developed effective means of communicating with and understanding the people who lived at the home.

Person centred care planning, monitoring and review had been introduced to the home earlier in the year and we could see that this was having a positive impact on the quality of life of the people who lived at the home, as discussed early in this report. Staff told us that they had received training and guidance on implementing person centred care planning and we could see that all the people had had the benefit of a person centred review. We could see from the various person centred reviews we looked at that the person, their needs wishes and aspirations had been at the centre of all decision making.

Plans had been drawn up as to what each individual wanted to achieve in the coming year and various members of the staff team were given designated responsibilities to facilitate the person achieving their goals. This is excellent care practice as it helps staff to empower people to achieve their goals and aspirations and provides a flexible framework by which staff and community based health and social care professionals can work together to provide the best possible outcomes for the person.

However, we could see that there was room for improvement in the implementation of the programme. We could see that some of the agreed goals had not been met, yet there was no written explanation as to why or what would be done to eradicate the problem. When we asked the team leader and registered manager about monitoring agreed goals they told us that they had not made any arrangements to do this and were unaware target dates had been missed. The registered manager gave assurances and subsequently provided an action plan that showed that effective quality assurance, monitoring and review arrangements would be made to ensure people were getting the support they needed to achieve their goals.

When there were sufficient staff on duty people were offered opportunities to get out and about in the local community. Key workers told us that some of the goals agreed at various people's person centred planning meetings, such as a trip to a local football club, had been missed because of staff shortages. However, it was clear that staff did their utmost to make the most of available resources and help people to go out and about as often as they wished.

Several people who lived at the home were benefiting from assistive technology including IPads and computer programmes to help them to communicate more effectively. One person had achieved great success on a shopping trip to the supermarket where by using an IPad and having the confidence to speak with store assistants unaided, they were able to get directions to the items they wished to purchase. Staff used various other methods to assist communication with the people who lived at the home including an easy read questionnaire which asked fundamental questions about the person's well-being. These were illustrated with a range of smiley to grumpy and sad faces designed to illicit their views on each question.

The home had a complaints policy and processes were in place to record any complaints received and to ensure that these would be addressed within the timescales given in the policy. Easy read guidance on how to raise concerns was detailed in each person's personal care files. There were no records of complaints received in the previous 12 months period. The manager told us that they had only ever received one complaint which had been responded to in writing and resolved to the satisfaction of the complainant.

Requires improvement

Is the service well-led?

Our findings

The registered manager was unfamiliar with the way the quality of care, facilities and services were assessed, monitored or continuously improved. The manager told us that he did not have access to a written policy as to how the quality of the service was assessed and evaluated.

We found that some systems and processes had been established to help ensure people were safe but these had not been carried out effectively so managers and staff were not learning from incidents and accidents. Therefore the health and well-being of the people who lived at the home was not assured.

The registered manager told us that PRN medicines audits should have been completed on a monthly basis but when we checked the records the last medicines audit carried out was dated May 2015. This meant that errors in the safe storage or administration of medicines had not been identified and therefore risk presented to the people who used the service had not been mitigated.

The registered manager or team leader told us that they were required to carry out a health and safety audit on a monthly basis but this had not been done in the last 12 month period. We could see that managers and staff were not routinely analysing accidents and incidents so opportunities to learn from past events and near misses were being lost and vulnerable people remained at risk of harm.

Records showed that routine fire safety checks of emergency lighting, fire door seals, and manual examination of fire extinguishers were scheduled to be inspected quarterly but had not been done since February 2015.

The registered manager told us that he had been struggling with staff shortages and had experienced difficulties managing staff holidays and absenteeism through sickness but these issues had not been raised or discussed at the service manager's monthly visit. Therefore the problem had persisted and an unsatisfactory situation which adversely affected people's quality of life or left them at risk of their needs not being met, had been allowed to continue.

The above issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes established to ensure compliance with the regulations were not operated effectively so the health and well-being of the people who lived at the home was not assured.

The registered persons are required to notify the commission of certain changes, events and incidents specified in the regulations. This is to enable the commission to see if the situation was handled correctly and if the service provider is complying with the law. The registered persons had not notified the commission that a standard authorisation for a deprivation of liberty safeguarding had been granted in respect of the care of a person who lived at the home.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009. Notification of other incidents. The registered persons must notify the commission without delay of the result of any application for a deprivation of liberty safeguard made in respect of any person accommodated at the home.

The registered manager responded to the issues we raised during our inspection and gave assurances that action would be taken bring about the necessary improvements. Following our inspection the manager wrote to the commission, provided an action plan and advised us that the provider was piloting a "Quality Assurance Framework" with the intension of launching it from April 2016. This will help to ensure that the quality of care facilities and services for people who live at the home receive safe and effective care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent In providing care and treatment of service users the registered person's and staff did not act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered persons were not ensuring the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered persons were not always providing the people who lived at the home with healthy and nutritious food suitable to sustain life and good health.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered persons did not always deploy sufficient numbers of suitably qualified, skilled and experienced staff to meet the assessed needs of the people who lived at the home.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered persons were not doing all that is reasonably practicable to mitigate risks to the health and welfare of the people who lived at the home.**

The enforcement action we took:
We served warning notices on the registered provider and the registered manager. We told them that they must comply with the regulations and do all that is reasonably practicable to mitigate risks to the health and welfare of the people who lived at the home by the 6 February 2016.