European Care Lifestyles (B) Limited

Oakhurst Nursing Home

Inspection Report

2 Oak Mount,
Manningham
BD8 7BE
Tel: 01274 544279
Website: www.europeancare.co.uk

Date of inspection visit: 15/04/2014
Date of publication: 06/10/2014

Contents

Summary of findings

Overall summary

Oakhurst nursing home provides accommodation and nursing care for up to 26 adults with mental health problems. On the date of the inspection there were 18 residents in the home. The service did not have a registered manager in post and had not since 1 March 2013. The new home manager had recently submitted an application to become the registered manager.

People told us they were happy living in the home, were safe and that staff were friendly and kind. People said they were free to do what they wanted to do. Some people told us they thought there wasn't enough to do in the home and would prefer more activities.

Systems and processes were in place to protect people from foreseeable harm, with staff aware of how to deescalate conflict and act on concerns in order to keep people safe. CQC monitored the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and hospitals. We found there were no DoLS orders in place and staff had received training on DoLS. We did not observe any restrictions of people's liberty during the inspection.

People were able to make choices in relation to their daily lives, for example choosing what they wanted to do and staff respected these wishes. However, there was no evidence people were involved in the review of their care plans. This meant people were not involved in long term care planning and setting objectives and goals. Care plans were not written in a format that promoted involvement of people that used the service and there was a lack of information provided to people on their care and treatment options. The problems we found breached Regulation 17 (Respecting and Involving people who use services), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Staff were up-to-date with a range of mandatory training and received regular supervision and support. However, there was no provision for Mental Capacity Act 2005 (MCA) or mental health training on the annual training programme which meant staff may not have the specialist skills and knowledge to meet some people's needs.

We found improvements had been made to the environment following our previous inspection, however further improvements were required to ensure all outstanding maintenance was completed, to give the home a more homely feel and to ensure people were able to make the most of the facilities and grounds available. The problems we found breached Regulation 15 (Safety and suitability of premises), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Staff displayed warmth and compassion with people and treating them with dignity and respect. People spoke positively about their relationships with staff.

People's needs were assessed and care and support was planned and delivered to meet people's individual needs. Support plans contained personalised information to ensure staff knew how to support people and meet their needs. Staff were familiar with people's individual needs and their key risks. In one case, the service could have been more pro-active in seeking advice to ensure responsive care and treatment following the completion of a capacity assessment which concluded the person did not have the capacity to make decisions about their personal care.

The manager had only been working at the service for two months, but had developed a plan to improve the service. Staff spoke positively about recent changes and were confident further improvement would be achieved. More could be done to involve people in the running of the service and ensure people's views, comments and opinions were used to make changes and drive improvement. Some risks to people's health, safety and welfare were not identified, and there was an underreporting of incidents which meant that some incidents were not analysed and investigated. There were no systems in place to identify safe staffing levels. The problems we found breached Regulation 10(Assessing and monitoring the quality of service provision), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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.

Are services safe?

People who used the service told us they felt safe and told us they did not have any concerns about their safety or that of others.

We found safeguarding policies, procedures and guidance were available to staff and there was evidence they were followed. Staff and management had a good understanding of what constituted abuse and the process for escalating concerns to keep people safe.

Staff had a good understanding of how to calm verbal conflict and had received training which gave them the skills to do this. Staff were able to confidently describe how they used these techniques to keep people safe.

Reported incidents were fully investigated by management to reduce the liklihood of a re-occurrence and keep people safe. However there was an underreporting of incidents which posed the risk that some incidents were not investigated. For example, we found an incident where a staff member found a smouldering bin in the lounge caused by unauthorised smoking and had to put it out with water. This incident was not reported. This meant that opportunities for lessons to be learnt in order to keep people safe were missed. Management had identified this risk and had spoken to staff in order to ensure more incidents were reported.

All staff had completed training on Deprivation of Liberty Safeguards (DoLS). DoLS aim to make sure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. We found there were no DoLS orders in place. We did not observe any restrictions of people's liberty during the inspection.

Staff had a good understanding of how to protect people's rights and support people in communicating. Staff had a mixed understanding of the requirements of the Mental Capacity Act 2005 (MCA) and had not received any dedicated training in the subject. This meant that staff may not be familiar with the correct legal processes to follow to protect the rights of people without capacity to make decisions for themselves.

Some risks to people's health and safety were assessed with clear control measures put in place. However during the inspection, we found two hazards that had not been identified by staff, putting people at risk.

The service had a positive approach to risk management, for example in maintaining people's freedom and supporting them to cook for themselves.

Summary of findings

Improvements had been made to the environment following the previous inspection, including new carpets and an outside pathway. However further improvements were required to some areas including bedrooms and bathrooms to ensure the building was adequately maintained. For example, in one room we found the floor covering around the sink was badly stained and needed replacing. In another person's room their carpet was covered in cigarette burns and required replacing. Curtains and furniture were also stained and in a bad state of repair in some people's rooms. The areas where poorly maintained equipment and premises were evident may have impacted on the wellbeing of residents as they were not a pleasant environment to live in.

Are services effective?

People said they were happy with the level of care and support they received. For example one person said "Yes the staff are good, they help me with my foot problem and when I need to go out." People said they were given choices, for example one person told us "The food is much better than it was, I like the choices, but if I need something else I can ask."

Support plans were in place which showed staff had assessed people's care needs and clear instructions were in place to allow staff to meet these needs through delivering appropriate care and support. There was evidence people's preferences, likes and dislikes had been obtained so staff could deliver personalised care. In people's daily records there was evidence staff had listened to people's views and respected their wishes. This showed us people had their views respected.

Staff had a good understanding of people's needs we asked them about. Staff were up-to-date with training topics which included conflict resolution, moving and handling, basis life support and equality and diversity. However, the training programme was geared towards elderly person care, for example there was no training specific to the care of people with mental health problems which meant staff may not have the specialist skills and knowledge to meet some people's needs.

People were offered choice with regards to their daily lives. For example, staff let people stay in their rooms if they wanted to, encouraged people to be involved in activities and conversation, being sensitive about how much encouragement was appropriate so that peoples rights were respected. Staff were able to give us examples of how they had supported people's independence for example in supporting them to access the community on their own.

Summary of findings

People were supported to maintain good health and had access to healthcare services. People told us they had access to healthcare professionals such as doctors. We saw people were referred appropriately, for example following weight loss.

Improvements were required to the design and decoration of the home to meet people's individual needs. People were unable to access and benefit from the roof terrace and greenhouse facilities as they were in a state of disrepair.

Are services caring?

People confirmed to us that staff were caring and told us they were happy with the care that staff provided. We found staff to be caring and compassionate to people who used the service, treating them with respect. Staff respected people's privacy and allowed them to spend time in their rooms and always knocked on doors before entering.

We observed staff spending some good one to one time with people, encouraging them and playing games, for example we observed one member of staff playing domino's with a resident. However through observations, we concluded more could have been done to engage and involve some people especially those with more challenging behaviour.

We observed staff respond in a caring way when people became upset or distressed. This included verbal and non-verbal communication techniques to calm them down and reassure them. We saw staff listened well to people and responded to their requests.

Are services responsive to people's needs?

People told us they were asked their views about the activities they wanted to be involved in and about routine care and support tasks. People said staff let them do what they wanted to do, for example one person said "Yes I can choose what I want to do, and that staff is a nice bloke" and another person said "I go out every day to Leeds, Bradford and other places, which I use my bus pass so it's free. I enjoy going out and if I need anything I can get it." Some people said they wished there were more activities to do in the home, for example one person said" "It's not bad here, could do with some more things to do as I get bored."

Improvements were required to involve people in care plan development and review, to ensure long term goals and objectives were set. Care plans were not written in a format which best promoted understanding and engagement with people that used the service.

Summary of findings

The manager told us that people had access to advocacy services if required. However this and other information was not available to people in a suitable format, although the manager had started developing a service user guide which would in the future be given to all people who used the service. This meant that people did not have access to clear information about this aspect of support available for them.

People had their individual needs regularly assessed and met. Care plans were regularly reviewed by nursing staff. A range of assessments were in place which provided information to staff on how to support people. Specialist assessments were in place where people had specific risks such as diabetes, to enable staff to deliver appropriate care.

Systems were in place to protect people from social isolation and although there were enough staff to meet people's basic needs, sometimes people were not involved by staff and left without interaction and stimulation which resulted in them becoming withdrawn.

Mental capacity assessments had been completed where people were considered to lack capacity to make decisions for themselves. In one case, the service could have been more pro-active in seeking advice to ensure responsive care and treatment following the completion of a capacity assessment which concluded the person did not have the capacity to make decisions about their personal care.

Are services well-led?

People who used the service praised the manager and said they were approachable and often visible.

Staff spoke positively about the new manager at the home and said that the home had begun to improve. For example one staff member said "The new manager has made a really positive impact and we have begun to see improvements across the board." They said they felt confident they could raise concerns confidentially and would not be discriminated against for airing their views.

The manager was dedicated to driving improvement in the home, and was able to give us several examples of improvements they had made in the last few months. We saw the manager had a service improvement plan to ensure the service continued to develop and improve.

The manager was developing systems to ensure the views of people who used the service were recorded but these were not in place at

Summary of findings

the time of the inspection. The results of the previous resident survey was unavailable and there was no evidence an action plan had been produced which meant the organisation had missed an opportunity to learn from people's past views and experiences.

There was a lack of clear aims, objectives or values of the home with staff and management providing inconsistent responses as to the home's direction. The manager told us the home lacked direction and that they were working on ensuring clear values and objectives were in place.

A range of audits were undertaken such as medication audits and there was evidence that action plans were produced and regularly monitored to drive improvement.

The service was not using any systems or processes such as a dependency tool to calculate safe staffing levels. This risked that there may not always be a suitable number of staff particularly if the number of people who used the service or their dependencies increased.

Summary of findings

What people who use the service and those that matter to them say

During the inspection we spoke with six people who used the service. People told us they felt safe in the home and that staff were kind and compassionate.

People said there had been some improvements to the facilities recently, for example one person said “The smoking area is better now, and I like talking to people when I go for a smoke.”

People said the service was effective and that they had access to healthcare professionals when they needed them. For example one person said “Yes the staff are good, they help me with my foot problem and when I need to go out.”

People said that staff gave them freedom and enabled them to choose what they want to do. For example one person said, “Yes I can choose want I want to do, and staff a is a nice bloke” and another person told us “I go out every day to Leeds, Bradford and other places , which I use my bus pass so it’s free. I enjoy going out and if I need anything I can get it.”

People said that the home could provide more activities. For example, one person said “Its not bad here, could do with some more things to do as I get bored. “

People praised the quality of the food in the home and said it had improved recently with one person saying “The food is much better than it was, I like the choices, but if I need something else I can ask” and another person said “Food is nice.”

People said the manager was approachable, friendly and visible about the home.

Oakhurst Nursing Home

Detailed findings

Background to this inspection

Oakhurst is a residential home for people with mental health problems and is run by European Care Lifestyles (B) Limited.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Before our inspection, we reviewed all the information we held about the service. This included an action plan submitted to us following the previous inspection detailing how the provider would achieve improvements to the premises and to its quality assurance systems. We contacted the local authority commissioning and safeguarding teams. This helped us decide which areas we wanted to look at in more detail.

We visited the service on 15 April 2014. We used a number of different methods to help us understand the experiences of people who used the service, including talking with people, observing the care and support being delivered and looking at documents and records that related to peoples support and care and the management of the service.

The inspection team consisted of a Lead Inspector, two additional inspectors and an Expert by Experience We were supported on this inspection by an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience spoke with people who used the service.

We spoke with six people who used the service, and four members of staff.

At the last inspection in November 2013, the service was non-compliant with Regulation 10; Assessing and monitoring the quality of the service provision and Regulation 15; Safety and suitability of premises. During this inspection, we checked whether the required improvements had been made.

Are services safe?

Our findings

We spoke with six residents about their safety in the home. People told us they felt safe and told us they did not have any concerns about their safety or that of others.

Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns. Staff said they felt they were able to raise concerns within the organisation and would be provided with sufficient support from the manager. They told us they were confident the manager would investigate and address concerns raised by staff or people that used the service. The manager told us there had been no safeguarding incidents at the home since January but was able to describe the action they would take if an incident did occur. This showed us both staff and management had a good understanding of how to raise safeguarding and other concerns to ensure people were kept safe from abuse.

We saw safeguarding policies were available and information on safeguarding and whistleblowing was displayed on walls which provided quick reference guidance to staff on how to raise a concern. The manager told us all staff were up-to-date with safeguarding training, which gave staff the skills to identify and act on allegations of abuse. We looked at computer based records which confirmed all staff were up-to-date with training.

The manager told us physical restraint was never used by staff and that staff used verbal de-escalation techniques to avoid the escalation of conflict. Staff confirmed this was the case and were able to confidently describe how they defused aggressive behaviour. Staff were up-to-date with behavioural training which gave them the skills to de-escalate conflict. This was delivered on the annual training programme and consisted of computer based learning as well as face to face learning. This ensured people were kept safe by staff who had appropriate training.

The provider had an incident management system underpinned by an incident management policy. We looked at the file of recent incidents which showed incidents were investigated and lessons learnt were documented so the organisation could learn from them. However, there was a lack of reporting of incidents. The provider's incident management policy stated all incidents should be reported "no matter how trivial." For example, on looking through a person's daily records, we found an incident which occurred on 14 April 2014, where a staff member found a smouldering bin in the lounge caused by unauthorised smoking and had to put it out with water, however this had not been reported. The manager agreed this should have been reported and we saw evidence they had identified under-reporting as a risk and had spoken to staff about the need to ensure all incidents were recorded. A lack of reporting incidents presents risks to people's safety as this does not allow them to be investigated to prevent a re-occurrence. The problems we found breached Regulation 10 (Assessing and monitoring the quality of service provision), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider had failed to analyse incidents that resulted in or had the potential to result in harm. You can see what action we told the provider to take at the back of the full version of the report.

Staff had a good understanding of how to protect individuals from discrimination and ensure that all people were included and communicated with. However staff had a mixed understanding of the Mental Capacity Act with some support staff unclear as to the requirements of the act. We looked at the staff training programme and found that Mental Capacity Act training did not form part of the annual training programme. This meant staff were not provided with up-to-date knowledge of the application of the act and how it should be applied to protect people's rights. Mental capacity assessments were in place which showed the service had assessed people's ability to make decisions for themselves. Where people were judged to lack mental capacity, information was in place stating how to ensure decisions made for people were in their best interest.

All staff had completed training on Deprivation of Liberty Safeguards (DoLS). DoLS aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. We spoke with the manager who told us there were no DoLS orders in place. We did not observe any restrictions of people's liberty during the inspection.

Each person who used the service had a range of risk assessments in place to keep them safe. People had specific risk assessments in place for example one person

Are services safe?

had a risk assessment which detailed how to keep them safe from falling as they had poor eyesight. Assessments contained detailed information to instruct staff on the control measures required to keep people safe.

The provider had a positive approach to risk taking so that people's freedom was not restricted. This included encouraging people to remain independent through the use of the skills kitchen, making drinks and going out into the community on their own. Risk enabling assessments were in place for use of this kitchen and showed the service accepted some level of risk in allowing people to live their lives and promote independence.

During the inspection we found two hazards that staff were not aware of, which could have presented harm to people who used the service. Firstly, we found a cupboard on the ground floor of the home which contained cleaning chemicals was not secured as the lock was broken. Secondly, we looked in the room of a person who used the service. They had bottles of bleach , which they had bought from the shop. Staff were not aware this person had bought bleach and there was no risk assessment in place. This meant that not all risks to people's health, safety and welfare were identified and managed by staff. We spoke with the manager about these two hazards who took immediate action to ensure the situations were made safe. The problems we found breached Regulation 10, (Assessing and monitoring the quality of service provision), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to identify, assess and manage risks relating to the health, safety and welfare of service users. You can see what action we told the provider to take at the back of the full version of the report.

At the previous inspection in November 2013, the provider had not taken adequate measures through maintenance to keep the environment safe. During this inspection, we checked to determine whether the required improvements had been made. We undertook a tour of the communal areas, bathrooms and bedrooms of the home.

Some improvements had been made to the premises to keep people safe. For example, the path outside the front had been re-laid to reduce the trip hazard, new carpets had been installed in several areas and the roof repaired to reduce the influx of damp into the building. However we found several areas where further improvement and maintenance was required. The general décor was tired and required redecoration to make the premises a more homely environment. Some bedrooms had stained and worn curtains, vinyl and carpeted floor coverings that were poorly maintained and needed repairing, and furniture such as stained chairs which required replacing. We found several bathroom areas where floors and walls required maintenance. For example, in one room we found the floor covering around the sink was badly stained and needed replacing. In another person's room their carpet was covered in cigarette burns and required replacing. Several of the unoccupied rooms needed work doing to them before they would be safe for people to stay in, for example, one room had an uncovered fuse box and pipework that needed boxing in and other rooms below the roof terrace suffered from damp.

The areas where poorly maintained equipment and premises were evident may have impacted on the wellbeing of residents. The manager told us there was a second phase of planned improvements to the environment which was to begin shortly and this would address some of the issues that we found. The problems we found breached Regulation 15 (Safety and suitability of premises), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to ensure adequate maintenance of the premises. You can see what action we told the provider to take at the back of the full version of the report.

Access to hazardous areas such as the roof terrace which the manager said was not safe due to maintenance issues, kitchen and staff areas was restricted to keep people safe. Window restrictors were in place to reduce the risk of falls from high levels. People's bedrooms were lockable to maintain the safety of belongings and people were able to manage their own keys.

Gas, electrical installations, window restrictors , fire equipment and the passenger lift were regularly maintained and serviced in accordance with legal requirements. We saw evidence the building was secure with access control in place to ensure the safety of people who used the service and staff. Improvements had been made to the external doors to ensure people left via one entrance to maintain security by better monitoring who was entering and leaving the home to keep people safe.

Are services effective?

(for example, treatment is effective)

Our findings

People told us they were happy with the level of care and support they received from the provider. For example one person said "Yes the staff are good, they help me with my foot problem and when I need to go out." People said they were given choices, for example one person told us "The food is much better than it was, I like the choices, but if I need something else I can ask."

During the inspection we reviewed five people's care records. Support plans were in place which showed staff had assessed people's care needs and clear instructions were in place to allow staff to meet these needs through delivering appropriate care and support. Information was present to guide staff in supporting people in a range of areas such as medication, mental health, personal care, communication and keeping people safe. Support plans were personalised and it was clear that people's specific needs, choices and preferences had been obtained in the completion of the plans. There was an "about me" section of the care plan which contained information on people's life history, preferences, likes and dislikes so staff were aware of these. In people's daily records there was evidence staff had listened to people's views and respected their wishes, for example, one person's records showed how they often declined involvement in activities and staff had respected this wish.

We observed staff gave people choices with regards to their daily lives. For example, people were asked what they wanted to eat and drink. Staff waited patiently for a response and listened to what people had to say. The manager told us they had introduced a new menu which we looked at. The feedback regarding it was positive from the people we spoke to. There was a good choice of options available each day. There was no evidence people were actively involved in the development of the menu, which the manager told us they had "created through their years of experience in the care sector."

Staff understood people's needs, choices and preferences. For example we asked staff about people's dietary requirements, personal hygiene and daily preferences and they were able to confidently describe the people's preferences we asked them about. Staff were up-to-date with training topics which included conflict resolution, moving and handling, basic life support and equality and diversity. However, there was no training specific to the care of people with mental health problems. We asked the manager about this who said that the training programme was "a generic programme dictated by head office and was geared towards older people's health rather than mental health". Dementia training was on the annual training programme; however the service did not routinely care for people with dementia. There was no training on mental health or associated conditions. The manager acknowledged that this needed to change.

We observed care in the home over the course of five hours. People were offered choice with regards to their daily lives. For example, staff let people stay in their rooms if they wanted to, encouraging people to be involved in activities and conversation and being respectful of the individual residents right to choose what they wanted to be involved with. We saw evidence staff enabled people to be independent. Staff were able to give us examples of how they had supported people's independence for example in aiding them to cook for themselves and support them to access the community on their own.

People were supported to maintain good health and had access to healthcare services. People told us they had access to healthcare professionals such as doctors. One person told us they had a problem with their foot so the service arranged for the "foot lady" to come and see them. We reviewed care records and saw evidence that people had contact with a range of healthcare professionals. For example, we saw one person had lost 5kg of weight in February 2014, they had been referred and put on a dietary supplement. Contact with all health professionals was recorded in care plans so that their advice could be followed by support staff. Staff told us they thought the service was excellent at referring people appropriately. The nurse on duty and they were able to confidently describe to us in detail the healthcare needs of the people we asked them about. This showed us nursing staff were aware of people's healthcare needs to enable people to receive appropriate care and treatment.

Each person who used the service had a hospital passport in place. A hospital passport is used in the event of a hospital admission to ensure hospitals have relevant information on people's needs and preferences, especially when people cannot speak for themselves. This helped to ensure a smooth transition between services if a person was admitted to hospital.

Are services effective?

(for example, treatment is effective)

There was no mechanism to provide people with information in an understandable format about the medicines they take and the health and treatment options available. Information was contained in care plans but it was not written in a suitable format which encouraged engagement with people that used the service.

We undertook a tour of the home to check whether people's individual needs were met by the adaption, design and decoration of the home. There were spacious living areas where people could spend time for example in the dining room and living rooms. Bedrooms were of a reasonable size to contain people's belongings and furniture and were lockable so people could have privacy. Improvements were required to ensure people could make the most out of the premises. For example, the roof terrace was closed due to maintenance issues. This was a useful space with a greenhouse which had previously been used to support people to grow vegetables. However both the terrace and greenhouse were in a state of disrepair. The manager told us they planned to have this area repaired but people could not benefit from this facility at the time of our inspection. There was no evidence people who used the service had been involved in the refurbishment plans for the service.

Are services caring?

Our findings

People confirmed to us that staff were caring and told us they were happy with the care that staff provided. Staff respected people's privacy and allowed them to spend time in their rooms and always knocked on doors before entering.

During our observations of care we found staff to be caring and compassionate to people who used the service treating them with respect. We saw staff address people in a dignified manner and treated people with kindness and compassion. For example, we saw a staff member encouraging someone to come for lunch, explaining that it was lunchtime in a clear and patient manner and using both verbal and non-verbal communication techniques. This approach resulted in the person being persuaded to come to the dining room for lunch.

We asked staff about people's individual needs and preferences and found staff had a good understanding about each person's support needs that we asked them about for example where they liked to spend time, and what activities they liked to be involved in. Staff told us they thought people in the home were well cared for and they did not have any concerns regarding the care and compassion displayed by other staff members.

People's dignity and diversity was respected. Staff understood the importance of ensuring people's independence was maintained and that people were free to go out whenever they wanted. For example, we saw people were free to leave the home, access the facilities in the lounge, use the smoking shelter or spend time in their room.

People were allowed privacy in their own rooms and we saw staff were respectful of not disturbing people, for example of one person who was asleep in their room.

We observed staff spending one to one time with people, encouraging them and playing games, for example one member of staff playing domino's with a service user. We concluded through observations that more could have been done to engage with some people especially those with more challenging behaviour. For example one person sat in the living room had his eyes closed for several hours but was responsive to staff when they asked the person questions. However, although they occasionally asked the person if they were ok, no prolonged effort was made to engage and involve them in care and support activities.

We observed staff respond in a caring way when people became upset or distressed. This included verbal and non-verbal communication techniques to calm them down and reassure them. Staff listened well to people and responded to their requests for example in supporting them to have a cigarette or answering any questions they had about the days events. Staff told us that people were listened to and asked for their views on care informally on a daily basis through regular support. Regular resident meetings were also held which provided a more formal mechanism for people to be listened to.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People told us staff were responsive to their needs, but some people told us they wished there was more to do. For example, one person said" "It's not bad here, could do with some more things to do as I get bored."

On observing care and reviewing people's daily records we found it was clearly recorded that people were asked for their views about activities and routine care and support tasks. There was evidence staff had respected their decisions including refusals. However there was a lack of evidence that people were directly involved in the development of their care plans and long term goals/ objectives. The care plans we reviewed had not been signed by the person or a relative/advocate to demonstrate their agreement to the plan. Care plans were not written in a format which best promoted understanding and engagement with people that used the service. For example plans were bulky and contained lots of text which may have deterred people from reading them. There was no evidence the service sat down with people and undertook regular reviews of care and support packages, evaluating what had worked well and what had not. The manager explained to us how they were currently developing a new style care plan which was more person centred and they hoped this would ensure a more person centred approach to care and involvement of people. We looked at one care plan which the service had begun to complete and found the paperwork was an improvement on the previous records however; work was needed to ensure a creative approach to involving people in the production and review of these new records.

The manager told us that people had access to advocacy services if required. However there was no clear information on display for people who used the service in an understandable format, explaining the roles of advocates and how they could help them and how they could be contacted. The manager showed us the service user guide which they were in the process of developing. This would give people more information about the service in an understandable format, including how to complain. The manager told us this was still in development and had not yet been given to people who used the service. This meant that information about the service their care and support options were not yet available in a format that people would understand.

The problems we found breached Regulation 17 (Respecting and Involving people who use services); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because people were not provided with appropriate information in relation to their care and treatment and there was no evidence that people were encouraged to understand the care and treatment choices available. You can see what action we told the provider to take at the back of the full version of the report.

We saw people's capacity was considered under the MCA when decisions needed to be made. In one care record we saw that the service regularly attempted to assist a person with personal care but the person always refused and this had become a risk to their health and welfare. The service had completed a capacity assessment and come to the conclusion that the person did not have the capacity to understand the risks associated with the lack of personal care. However, following the conclusion of the assessment, the service had not been pro-active in taking action, for example in seeking advice from the relevant agencies with the aim of ensuring the personal care needs of this person were met. This risked that the person did not receive appropriate care in an area where they had been judged to lack the capacity to understand the consequences of refusing this care.

Care plans were regularly reviewed by nursing staff. A range of assessments were in place which provided information to staff on how to support people. Specialist assessments were in place where people had specific risks, for example one person who had diabetes had a diabetes care plan which guided staff on how to provide appropriate diabetes care, including diet and regular blood sugar monitoring. This person also had a skin assessment in place as they suffered from a skin condition; the advice in the care plans was personalised and specific to guide staff in delivering appropriate care.

In care records we found care plans were in place for relationships and social contact. These care plans guided staff on how to ensure people maintained and promoted relationships. Information was present on where they liked to spend their time and the friends that liked to visit them. We saw evidence people were encouraged to interact, for example one person's care plan stated "to be encouraged to join others at mealtimes." Activities were available for people to be involved in, such as board games, quizzes and trips out into the community, although some people told

Are services responsive to people's needs?

(for example, to feedback?)

us there wasn't enough to do. An activities rota was on display, although when we arrived it was an old rota from March 2014, the manager updated this during our visit. The latest rota showed activities such as film nights. People were also free to go out into the community on their own and during the inspection we saw several people do this.

Staff told us that they had enough time to provide care and support to people. However more could be done to interact with some people and provide more personalised care and support. There were enough staff to meet people's basic care needs but sometimes people were left without interaction and stimulation which resulted in them becoming withdrawn.

There was a lack of information available to advise people how they could record their complaints through comments, suggestions or complaints. Although we saw a complaints procedure was in place, no easy read information available to people who used the service to inform them of how to raise issues. This meant that people may not always have the opportunity to air their views.

Are services well-led?

Our findings

There was a manager at the home who had applied to be registered with CQC

We saw the manager interacted well with people who used the service and it was clear they were aware of people's care and support needs. People who used the service praised the manager and said they were approachable and often visible. This showed us that the manager was involved in the day to day delivery of the service so they were more likely to understand what was good and what required improvement in the service.

The manager told us they had managed the home for just over two months, and were in the early stages of implementing their plans and vision for the service. The manager showed us documentation which listed their key priorities for the service. This included ensuring support plans were more personalised, introducing a recovery plan, ensuring improvements in the environment and increasing the level of activities. We found the manager had a positive attitude towards driving improvement in the home. They were able to tell us of several improvements they had made to the home during their short time in charge, this included changes to the menu and the provision of fresh food instead of frozen

Staff all spoke positively about the recent change in management and told us they thought the service had started to improve. For example one staff member said "The new manager has made a really positive impact and we have begun to see improvements across the board." Staff said the manager was fair and open and that the manager would effectively deal with any concerns or complaints raised. Staff said they felt confident they could raise concerns confidentially and would not be discriminated against for airing their views. We found whistleblowing formed part of staff training on induction and the manager told us they now discussed it at each staff supervision.

We found there was a lack of clear objectives, values and direction at the home. The manager told us they thought the home had lost direction but that they were working on improving this. They told us they were currently reviewing the mission statement for the organisation. We found staff were unclear as to the objectives of the service, for example one staff member said it was a rehabilitation centre and others we asked did not know the aims of the service. There was no evidence on staff appraisal or supervision documentation or staff meeting minutes that the aims, objectives or values of the organisation were discussed so that these were promoted through the organisation.

We asked the manager how people were involved in the running of the service. The manager told us that staff involved people on a day to day basis, for example asking them what they wanted to do and how they wanted the service to deliver support. In addition, monthly resident meetings were in place. We saw evidence that these took place although looking at the minutes of the meetings; we found more could be done to record people's views, choices and opinions as there was only limited information recorded.

We saw evidence the manager had tried to organise a cheese and wine evening to engage with the relatives of people who used the service. They told us that this had not worked out as nobody had attended however in light of this they were reviewing how they were best able to engage with people's relatives in order to seek their views and feedback.

The manager told us they had plans to improve involvement in the running of the service, for example through involving people in the staff recruitment process and gaining their views through regular surveys and questionnaires. The manager told us that in the coming months they planned to ensure people were able to regularly write down their views on the service as they felt they would get more honest responses this way. At the last inspection in November 2013, the previous manager told us that following the latest service user surveys, action plans would be produced to ensure people's views were acted on. However when we asked the manager whether any information from previous surveys was available they said it wasn't. This meant there was no evidence that any learning or improvement had been made by the service following previous survey results. The problems we found breached Regulation 10 (Assessing and monitoring the quality of the service provision), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to seek and act on the views of people regarding the standard of care and treatment provided. You can see what action we told the provider to take at the back of the report.

Are services well-led?

Some systems were in place to identify risks to the service, for example risks posed by the environment, the lift and food upstairs. Care records showed each person had an emergency plan in place which guided staff on how to ensure each person was evacuated safely from the building in the event of a fire.

We asked the manager if any complaints had been received about the service. They told us that none had been received since they became manager two months previously. We looked at a complaint from January 2014. Although it had been responded to, it had not been closed down and there was no evidence of any lessons learnt from the incident. This meant that there was a risk that any failings in the service were not properly addressed.

We saw systems were in place to investigate incidents and accidents and that analysis of each incident took place so that lessons were learnt and the service improved. There was evidence that these were reviewed by the manager and audited by the area manager to ensure the correct process had been followed.

A range of audits were undertaken by the manager as part of the organisations quality assurance process. For example medicine audits, fabric of the building, health and safety were done. There was evidence that issues were picked up and action taken to address. The manager had identified the need to ensure care plans were updated to become more person centred and had begun this process. We saw evidence that there were systems in place to ensure the quality of care delivered by staff was monitored. Staff meetings were held as well as regular observations of practice, supervision and appraisal.

We asked the manager how they ensured there were enough staff to meet people's needs. They told us that they were not using any form of tool at present to evaluate the support people required, assistance with care tasks and activity demands to ensure safe and sufficient staffing levels were in place. They told us they ensured a minimum of two care staff during the day but preferred three care staff to ensure sufficient activities were available to cater for the 18 residents in the home, however we found there was no supporting evidence as to how the service came to this conclusion. The home had several vacancies and we were concerned particularly if resident numbers increased, the lack of a formal tool for determining staffing levels could result in insufficient staffing levels. The problems we found breached Regulation 10 (Assessing and monitoring the quality of the service provision), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to assess and monitor the quality of its service with regards to safe staffing levels. You can see what action we told the provider to take at the back of the report.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 (2)(b), (2)(c)(i), HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and Involving People: 17.(2)(b)People were not provided with appropriate information and support in relation to their care or treatment. 17.(2)(c)(i) People were not encouraged to understand their care and treatment choices available.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 (1) (c) HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises: 15 (1)(c)People were not protected against the risks associated with unsafe or unsuitable premises by means of adequate maintenance and the proper use of surrounding grounds.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 (1)(a), (1)(b), 2(c)(i),2(e), HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and Monitoring the quality of service provision 10.(1)(a)Systems were not in place to regularly assess and monitor the quality of the services 10.(1)(b) Risks to the health, safety and welfare of people who used the service were identified, assessed and managed. . 10.(2)(c)(i) An analysis of incidents that resulted in or had the potential to result in harm did not always take place. 10.(2)(e) The views of people who used the service or those acting on their behalf were not regularly sought