Calderdean Ltd

Raycroft Unit

Inspection report

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Date of inspection visit: 24 February and 03 March 2015
Date of publication: 07/09/2015

Ratings

Overall rating for this service	Inadequate
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?	Inadequate

Overall summary

The inspection was unannounced and took place on 24 February and 03 March 2015.

The previous full inspection at the Raycroft Unit was carried out on 12 February 2013. The service was judged to be non-compliant in three outcomes, infection control, supporting workers and quality assurance. The home was re-visited on 12 June 2013 and the provider had made the necessary improvements to meet the relevant requirements, however was judged to be non-complaint for not having an effective complaints procedure in place. We revisited the home on 05 February 2014 and the provider had made the necessary improvements to meet the relevant requirements.

The Raycroft Unit is registered to provide care for up to 11 older people who do not require nursing care. It is situated in a residential area of Morecambe. At the time of our visit there were 11 people who lived there. Accommodation is on two floors with a stair lift for access between the floors. All rooms are ensuite. The home is situated close to shops, buses and the local facilities of Morecambe.

Summary of findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection the registered manager was not present. We spoke with the care manager and a director of the company that operated the service.

We spent time in all areas of the home, including the lounge and the dining areas. This helped us to observe daily routines and gain an insight into how people's care and support was managed. During our visit we saw staff had developed a good relationship with the people they supported. Those people who were able to talk with us spoke positively about the service and told us they felt well cared for. One person told us, "The staff are all very nice. I can't say anything about them."

Through our observation and discussions with people we noted that a number of systems to monitor the quality of the service and keep people safe had failed. There were numerous breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant the service was not safe, effective, caring, responsive or well-led. You can see what action we told the provider to take, can be seen at the back of the full version of the report.

Staff spoken with understood the procedures in place to safeguard vulnerable people from abuse. However risks to one person were not being managed appropriately to keep them safe. We also observed that one person's liberty was deprived without the authorisation of the appropriate supervisory body. You can see what action we told the provider to take at the back of the full version of the report.

The staffing levels at night were inadequate to keep people safe. There was only one member of staff on duty at night time. Staffing levels were not assessed and monitored to make sure there were sufficient staff on duty to meet people's individual needs and to keep them safe. You can see what action we told the provider to take at the back of the full version of the report.

The registered manager and provider had not taken steps to ensure contractors had undertaken electrical safety tests within the industry recommended timescale. There were shortcomings in the fire safety arrangements. In addition there had been no maintenance work undertaken to secure the building. Suitable arrangements were not in place to manage the risks to the health, safety and welfare of people who lived at the home. You can see what action we told the provider to take at the back of the full version of the report.

We looked at how medicines were managed and found appropriate arrangements for their recording and safe administration. Records we checked were complete and accurate and medicines could be accounted for because their receipt, administration and disposal were recorded accurately.

The provider had failed to implement thorough recruitment practices to ensure that staff employed to work at the home were suitable for their role. You can see what actions we asked the provider to take at the back of the full version of the report.

Staff had not completed infection control training and improvements were required to the environment to minimise the risk of cross infection for people who lived at the home, staff and visitors. You can see what action we told the provider to take at the back of the full version of the report.

Suitable arrangements were not in place to ensure staff received appropriate training to carry out their role and responsibilities. Training requirements for staff members had been identified but not delivered. You can see what action we told the provider to take at the back of the full version of the report.

People were involved and consulted with about their needs and wishes. Care records provided information to direct staff in the safe delivery of people's care and support. However records needed to be kept under review so information reflected the current and changing needs of people.

Staff had a good understanding of people's daily care needs and where necessary, ensured that people who used the service had access to community health care and support. Community professionals reported positive relationships with the service and felt staff were professional and cooperative.

Summary of findings

Calderdean Limited are registered with the Care Quality Commission to provide a service at two locations. Raycroft Unit and Alders Residential Home. In August 2014 the registered manager for Raycroft had taken on the extra responsibility of managing the Alders and had based himself at the Alders Residential Home from August 2014. There was no clear leadership at the Raycroft Unit. The systems to monitor the quality of the service and keep people safe had failed. You can see what action we told the provider to take at the back of the full version of the report.

It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify the Commission without delay of the death of a person who lived at the home. In addition the provider should notify the Commission of other incidents including the serious injury to a person. This is so that we can monitor services effectively and carry out our regulatory responsibilities. We noted during our inspection that deaths and incidents which had resulted in a person receiving treatment at hospital should have been notified to CQC. The registered manager or provider should have submitted these. Our systems showed that we had not received any notifications. 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.

People told us they felt safe living at the home.

There was not enough staff on duty at night to keep people safe and risks were not always assessed in a timely manner or appropriate action taken to keep people safe.

Suitable arrangements were not in place to ensure safe recruitment practices were followed.

Suitable arrangements were not in place for the security of the building, electrical safety, fire safety arrangements and infection control to keep people safe.

We reviewed medication administration and practices at the home and saw that appropriate arrangements were in place for storing, recording and monitoring people's medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Training had been identified with staff but we found that staff had not completed the relevant courses to give them the necessary knowledge and skills to support people effectively.

Staff did not understand the requirements of the Mental Capacity Act 2005. We observed that one person's liberty was deprived without the authorisation of the appropriate supervisory body.

Records showed that all people who lived at the home were assessed to identify the risks associated with poor nutrition and hydration. Where risks had been identified, management plans were in place.

We saw people's health needs were monitored and advice had been sought from other health professionals where appropriate.

Is the service caring?

Good

The service was caring.

There was evidence people's preferences, likes and dislikes had been discussed so staff could deliver personalised care.

Staff treated people with patience, warmth and compassion and respected people's rights to privacy, dignity and independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

Records showed people and their family members had been involved in making decisions about what was important to them. People's care needs were kept under review. However care plans were not always updated to reflect the changes.

People told us there was a personal approach to activities. They took part in activities which were of interest to them. There was a structured programme of activities.

The staff team worked very closely with people and their families to act on any comments straight away before they became a concern or complaint.

Is the service well-led?

Inadequate 

The service was not well-led.

Through our observations and discussions with people, we noted that a number of systems to monitor the quality of the service and keep people safe had failed.

There was no clear leadership at the home and the provider did not understand their legal responsibilities for meeting the requirements of the law.

Raycroft Unit

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and took place on 24 February and 03 March 2015. The inspection team consisted of an adult social care inspector and a bank inspector.

We reviewed information we held about the home, such as statutory notifications, safeguarding information and any comments and concerns. This guided us to what areas we would focus on as part of our inspection.

We spoke with a range of people about the service. They included eight people who lived at the home, two visiting family members, a visiting health professional and three staff members. We also spoke with a director of the company that operated the service. In addition we spoke to the contracts and commissioning department and safeguarding team at the local authority. This helped us to gain a balanced overview of what people experienced when living at this home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spent time looking at records, which included three people's support records, training and recruitment records for three members of staff and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

People who lived at the home told us they felt safe when being supported. One person told us, "All the staff are very nice. I feel safe with them and living here." A family member told us, "I have no concerns about the staff at all."

We saw there were safeguarding policies and procedures in place. Staff were knowledgeable about the actions they would take if they witnessed any abuse taking place. One member of staff told us, "I would tell the manager if I felt something was wrong. I would have no hesitation."

In our discussions staff told us they were aware of the home`s whistle blowing policy. We saw the policy outlined the procedure to follow should any of the staff have concerns or suspicions where people who lived at the home were at risk. This instructed staff to raise their concerns with the management team. However there was no recognition within the policy that there may be circumstances where staff can report a concern to an outside body, such as the local authority or the Care Quality Commission (CQC).

We looked at the current employment contract for staff which stated, 'If you wish to make a 'protected disclosure' also known as a 'whistle blower' disclosure, you must do so to a director or the owner only.' Under the Public Interest Disclosure Act 1998 (PIDA) workers who act honestly and reasonably are given automatic protection for raising a matter internally. Protection is also available to people who make disclosures to regulators such as the Care Quality Commission. It also makes it clear that any clause in a contract that seems to prevent an individual from raising a concern that would have been protected under PIDA is void. We spoke with a director of the company that operated the service about the recent change in employment contracts. She told us, "I have not read them in detail. I just bought them on line."

We looked at how risks to individuals and the service were managed so that people were protected. Where people may display behaviour which challenged the service, we saw evidence in care records that risk assessments and plans of care were in place. These were detailed and meant staff had the information needed to keep people safe.

We looked at one person's care records to determine what arrangements were in place to keep this person safe. The plan of care written in November 2013 when the person was admitted to the home stated, 'Mobility and transfer no problems – can sometimes get unsteady if feeling unwell.' We reviewed the accident forms which had been completed following incidents involving this person. In the first six months after admission there were 18 incidents where the person was found on the floor. The care plan was reviewed three times before being changed on 31 May 2014 to note, "[Person needs one carer with her when walking round]. Since 31 May 2014, this person has had a further 19 incidents where the person was found on the floor.

We spoke with the care manager about how the risks to this person were being managed. She told us the GP had been regularly involved reviewing medication for an infection. However there had been no changes within the home to reduce the risks of falls and protect the person. Whilst risks were identified and assessed, suitable arrangements were not in place to manage the risk. In addition the arrangements were not reviewed following incidents to ensure necessary action was taken to keep the person safe.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked at the recruitment and selection procedures the provider had in place to ensure people were supported by suitably qualified and experienced staff. We looked at records for two members of staff. Staff had completed an application form however a full employment history was not provided for staff. There was no evidence that any gaps in employment history were explored and explained for each person. References were obtained before people started work however not always sought from the last employer.

We were told by staff on duty that Disclosure and Barring Service (DBS) checks had been undertaken before they started work. However there was no evidence that a DBS check had been completed. A DBS certificate allows an employer to check the criminal records of employees and potential employees to assess their suitability for working with vulnerable adults.

We spoke with the care manager and director about our observations. The director told us, "I am not aware of these. The manager would have responsibility for recruiting staff." Safe recruitment practices were not followed.

Inadequate

Is the service safe?

This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

We reviewed how the service was being staffed to make sure there was enough staff on duty at all times, to meet people's needs and keep them safe. People we spoke with told us they were happy with the care and support they were receiving. They told us they felt there were enough staff on duty to meet their needs and that staff had time to spend with them. One person told us, "I like being on my own but staff are available if I need them." Another person told us, "Staff are brilliant." However one family member we spoke with told us, "The staffing levels are inadequate but it has been better recently." Another family member told us, "I can't criticise the staff, but maybe there is not enough."

We looked at the homes duty rota. On the first day our visit there was three members of staff on duty between 8:00 and 13:00 and between 16:00 and 18:00. There was two staff on duty between 13:00 until 16:00 and between 18:00 and 22:00. There was one member of staff on duty throughout the night.

During our observations we saw staff were responsive to the needs of people they supported. However we did observe on one occasion in the afternoon when there was two members of staff on duty, they were both needed to attend to a person who required assistance from two members of staff. They assisted the person into a wheelchair in the lounge and escorted the person back to their room and assisted them into bed. Then with the bedroom door shut they provided personal care and changed the person's clothing before settling them to rest. This took approximately 15 minutes, during which time there was no member of staff available for oversight of the other people or available to respond to any emergency.

We spoke with staff members about staffing levels at the home. One staff member told us, "We could do with some more staff. There are three on today but sometimes it is two if someone phones in sick and we can't get cover."

We spoke to the care manager about staffing arrangements at the home. She told us there was no cook or domestic staff employed. Staff completed domestic work as part of their job role. This took them away from their role of caring for people. We also expressed our concern that there was only one person on duty at night. The care manager explained there was one person who required the assistance from two members of staff to mobilise, another person required assistance from two members of staff to get out of bed and seven people who mobilised with zimmer frames.

We asked if staffing levels were assessed and monitored to make sure there were sufficient staff on duty to meet people's individual needs and to keep them safe. The care manager told us, "It would have been the manager's responsibility." The care manager and director were unable to demonstrate what analysis and risk assessment had been used to determine sufficient staffing levels. The staffing levels at night were inadequate to keep people safe.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We looked at what arrangements and plans were in place to respond to emergencies. The care manager provided us with a file which contained all records related to fire safety. She was unable to locate a fire risk assessment or an evacuation plan. We saw that along emergency routes and exits there were a number of fire doors that were found either wedged in the open position, door closing devices disconnected/ missing or not effectively closing into their frames.

The Lancashire Fire and Rescue Service carried out a fire safety inspection at the home during our visit on 24 February 2015. As a result of their findings an enforcement notice was issued for failure to comply with The Regulatory Reform (Fire Safety) Order 2005. The provider has been given until 23 March 2015 to forward to the Lancashire Fire and Rescue Service evidence of compliance in all areas.

During our inspection we noted that the premises were not secure. Several windows were not restricted to open safely. This meant people could be at risk of falling due to the wide opening of the windows. The care manager and director were unable to provide us with any gas certificates to support all gas appliances within the home were safe. However the care manager was able to show us a sticker on the gas boiler which showed the boiler had been recently serviced. We also found that electrical safety and annual

portable appliance (PAT) testing for all electrical equipment was out of date. This meant that the provider had not ensured safety checks were carried out to assist with keeping people safe.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

We looked at what procedures and systems were in place to manage infection control in the home. We also looked around the home to see what hygiene controls were in place.

Infection prevention and control policies and guidelines were available. Staff we spoke with demonstrated an understanding of the need to follow infection prevention and control procedures and gave examples of how this worked in practice. However when questioned, staff were unaware of the five key stages for hand hygiene. Training records we reviewed for three members of staff showed they had not completed infection control training.

We spoke with a health professional, who was visiting the home on 03 March 2015. We asked for their views on how well people were protected by the prevention and control of infection. The professional told us improvements were required to the environment and staff needed a better understanding to minimise the risk of cross infection for people who lived at the home, staff and visitors.

We saw cleaning schedules were in place. These listed daily, weekly and detail tasks. All schedules had been signed by staff to confirm tasks had been completed. When we looked round the home we saw daily tasks for the communal and people's bedrooms had been completed.

However we noted furniture was not washable and some chairs were stained. A communal commode was not sufficiently cleaned. This poses a risk as people can be exposed to cross infection from using communal items.

We also noted there was limited space in the laundry room which meant that procedures for keeping soiled and clean laundry separate was not easily managed.

People were not protected by the prevention and control of infection.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked at how medicines were administered. We saw people's medicines needs were checked and confirmed on admission to the home. Medicines were safely kept and we saw appropriate arrangements for storing, recording and monitoring controlled drugs (medicines liable to misuse). The home worked with the local pharmacy to ensure they had adequate stocks in place. There was a system in place for returning any surplus stocks of medicines.

We looked at medication administration records for all people who lived at the home following the morning medication round. Records showed all morning medication had been signed as having been administered. We checked this against individual medication packs which confirmed all administered medication could be accounted for. This meant people had received their medication as prescribed.

We spoke with people about the management of their medicines. They told us they had provided consent for staff to administer their medication and had no concerns. One person said, "I am happy they look after my medicines for me. They make sure I receive my tablets when I need them."

Requires Improvement

Is the service effective?

Our findings

The feedback we received from people who lived at the home and their family members was positive. People told us they felt their carers understood their needs and said they received a good level of care and support. One person commented, "The staff are brilliant." A family member we spoke with told us, "They know what they are doing."

We looked at training records for three members of staff. Records showed the members of staff had not completed key training in all areas of safeguarding vulnerable adults, moving and handling techniques, first aid, medication, infection control, and fire training.

Staff members we spoke with told us that training was discussed with the registered manager. One staff member told us, "We don't have time for training. We are expected to take a DVD home and do the training at home, but not everyone can learn like that."

The staff members we spoke with told us they received regular formal supervision sessions with their manager, in addition to an annual appraisal. These meetings gave staff the opportunity to discuss their own personal and professional development as well as any concerns they may have. We noted from the records that we looked at, that training was identified for members of staff as part of the supervision but had not been addressed. For example it was identified for one member of staff in September 2014 that first aid, food hygiene, risk assessment and moving and handling training was required. The member of staff confirmed this training had not taken place. They told us, "We discussed training with the manager but it doesn't happen, we just don't have time to do it."

Suitable arrangements were not in place to ensure staff received appropriate training to carry out their role and responsibilities.

This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

There were policies in place in relation to the MCA and DoLS. We spoke with staff to check their understanding of the MCA. Staff were unable to demonstrate an awareness of the legislation and associated codes of practice and confirmed they had not received training in these areas. One staff member told us, "It's not something I have heard of." Suitable arrangements were not in place to enable staff to assess people's mental capacity, should there be any concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

We observed daily routines to gain an insight into how people's care and support was managed. We noted one person was upset and distressed and asked to go home throughout the first day of our visit. Staff told us that the person lacked capacity and could appear upset and wanting to go home on a regular basis. We looked at the person's care records. There was no mental capacity assessment or best interest decision in place to identify that it may be in the person's best interests to be cared for in a way that amounts to a deprivation of liberty in order to safeguard them.

We spoke with the director of the company operating the service and informed them that the person was being deprived of their liberty without the authorisation of the appropriate supervisory body. We asked the provider to submit an urgent and standard authorisation, in accordance with the provisions of the MCA. The director told us that she did not have an understanding of the MCA and didn't know how to complete a DoLS authorisation. The director told us she would, "Get somebody to do it." When we revisited on 03 March 2015, the provider had not completed or submitted the authorisations.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding people from abuse and improper treatment.

Requires Improvement

Is the service effective?

The people we spoke with told us they enjoyed the food provided by the home. They said they received varied, nutritious meals and always had plenty to eat. They told us they were informed daily about meals for the day and choices available to them. One person said, "I'm happy with the food." Another person told us, "I enjoy the food. It is tasty and plenty of it."

We observed lunch being served in a relaxed and unhurried manner. We saw people were provided with the choice of where they wished to eat their meal. All but one person chose to eat their meal in the dining room. People sat at the table and engaged in conversation with each other. We observed the meal was well presented and looked and smelt appetising. We noted people were given time to eat their meal without being hurried. Drinks were provided and offers of additional drinks and meals were made where appropriate. We heard people informing the staff member how much they had enjoyed their meal. One person said, "That was really lovely. I am so full I couldn't eat another thing."

We spoke with the staff member about meal preparation and people's nutritional needs. They confirmed they had information about special diets and personal preferences and these were being met. They told us this information was updated if somebody's dietary needs changed.

Care plans reviewed detailed information about people's food and drink preferences. All care plans we looked at contained a nutritional risk assessment. People's weight was regularly monitored. We noted people who were in danger of losing weight and becoming malnourished were given meals with a higher calorific value and fortified drinks. We saw appropriate referrals had been made to other health professionals, where there had been concerns about a person's dietary intake.

People we spoke with told us they had access to healthcare professionals to meet their health needs when this was required. One person told us, "Yes we are supported to go to the doctors, dentist and if needed the optician." Another person told us, "I am well at the moment. If I wanted to see my doctor they would arrange this for me."

People's healthcare needs were carefully monitored and discussed with the person as part of the care planning process. Care records seen confirmed visits from General Practitioners and other healthcare professionals had taken place. The records were informative and had documented the reason for the visit and what the outcome had been. This confirmed good communication protocols were in place for people to receive continuity with their healthcare needs.

During our inspection we spoke with a visiting district nurse. Feedback was positive. They told us relationships with staff at the home were supportive and any referrals regarding a person's health were timely. This showed there was a system in place for staff to work closely with other health and social care professionals to ensure people's health needs were met.

Good

Is the service caring?

Our findings

People we spoke with all expressed they were very satisfied with the service and the care they received. One person told us "The staff are brilliant. They can't do a thing wrong even when I have been in tears every day they have been there for me." People told us they had a good relationship with the staff, who they described as "caring, and supportive." A family member we spoke with, told us, "I can't praise the staff highly enough. The residents are looked after."

We spoke with three members of staff. All were respectful of people's needs and described a sensitive and caring approach to their role. Staff told us they enjoyed their work because everyone cared about the people who lived at the home. One staff member said, "It's really homely here. Like a big family."

Staff spoke fondly and knowledgeably about the people they cared for. They showed a good understanding of the individual choices, wishes and support needs for people within their care. One staff member told us, "We take time to get to know the people we care for so that we can provide care the way they like it."

During our inspection we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with the people in their care. SOFI helps us assess and understand whether people who use services are receiving good quality care that meets their individual needs. We saw that staff knew the people they cared for and had a warm rapport with them. There was a relaxed atmosphere throughout the building.

During our observations staff showed warmth and compassion in how they spoke with people who lived at the home. We noted through our observations that staff were very patient when dealing with people who repeatedly asked them the same question in a short space of time. We observed that one person appeared agitated. A member of staff demonstrated patience and understanding of the person's condition to diffuse the situation safely in a caring and compassionate way. We also saw staff were very patient when accompanying people to transfer from one room to another. This showed concern for people's well-being whilst responding to their needs and an awareness of supporting people to remain independent whilst ensuring their safety.

The care plans we viewed were based on people's personal needs and wishes. Everyday things that were important to them were detailed, so that staff could provide care tailored to meet their needs and wishes. People we spoke with were confident that their care was provided in the way they wanted. However some people told us they didn't get involved with their care plans as they preferred to leave this to their family. People felt their family's views were taken into account. We saw evidence to demonstrate people's care plans were reviewed with them and updated on a regular basis.

The service had policies in place in relation to privacy and dignity. We spoke with staff to check their understanding of how they treated people with dignity and respect. Staff gave examples of how they worked with the person, to get to know how they liked to be treated. One staff member told us, "The residents are individuals and we help them to get up when they want to, when they are ready. We respect people's wishes."

People who lived at the home told us they felt their dignity and independence was respected. One person told us, "I am a bit independent and like to have a bath. The staff are really good. They know what I want and respect it."

Requires Improvement

Is the service responsive?

Our findings

Throughout the assessment and care planning process, staff supported and encouraged people to express their views and wishes, to enable them to make informed choices and decisions about their care and support. For example what time they wanted to get up, what their food preferences were or what hobbies or interests they had.

People who lived at the home were allocated a named member of staff known as a key worker. This enabled staff to work on a one to one basis with them and meant they were familiar with people's needs and choices. We saw that as part of the care planning process, the key worker would review and discuss the person's care and support with them. Records we looked at showed these reviews had taken place.

However where people lacked capacity there was no evidence the person's best interests had been considered under the Mental Capacity Act 2005. We saw no details of capacity assessments included in people's care records. Where specific decisions were needed to be made about people's support and welfare; additional advice had not been sought. There was no evidence people were able to access advocacy services should they need to. This is important to ensure the person's best interests are represented and staff can respond to people's choices about their care.

We saw good examples where the home had responded to changes in people's needs. We saw timely referrals had been made to external professionals. For example a referral had been made to the GP when one person had a recurring infection. We also noted one person was at high risk of developing pressure sores and had been provided with a pressure relieving mattress. However we noted that care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

We looked through three people's care records with the care manager and noted where there had been changes to a person's care needs between formal reviews, the care records had not been updated to reflect the changes and how best to support those people. For example the care plan detailed that one person had experienced a high level of falls. Whilst a referral had been made to the GP, there had been no timely changes in the care plan to demonstrate the arrangements they had put in place to respond to the increased risk for this person.

People we spoke with were happy with the activities. We saw from care records that people's individual interests and wishes had been identified to provide a personal approach to activities. There was a structured programme of activities. A notice board in the reception area advertised which activities were planned for that day. During our observations in the afternoon we noted people engaged in the activities. People told us they had enjoyed taking part. One person told us, "There is something on every afternoon." Another person told us, "I don't always like to take part, but enjoy watching."

People were enabled to maintain relationships with their friends and family members. We met two family members who were visiting their relatives. Family members told us they were always made to feel welcome when they visited the home. One family member told us, "I can have a laugh with the staff. I don't ever feel I am in the way."

The service had a complaints procedure which was made available to people they supported and their family members. The care manager told us the staff team worked very closely with people and their families and any comments were acted upon straight away before they became a concern or complaint.

Family members we spoke told us they were aware of how to make a complaint and felt confident these would be listened to and acted upon. One person said, "I've not had any concerns but I know I can speak to the staff anytime if anything needs sorting."

Inadequate

Is the service well-led?

Our findings

There was a lack of processes in place to get the views of people who lived at the home on a formal basis. When we asked people if they had 'resident meetings' or had filled in any questionnaires about the quality of the service, they said no. One person told us, "We haven't had any meetings and I can't remember being asked to complete a questionnaire." Another person told us, "No I don't think we do. The staff always ask if I'm alright."

There was no evidence that any comments or complaints had been taken into account and dealt with through the home's formal procedures. This meant that there was no effective system in place to record people's views and to understand where improvements were needed.

All staff spoke of a strong commitment to providing a good quality service for people who lived at the home. Staff confirmed they were supported by the registered manager and enjoyed their role. One staff member told us, "The place was alive when the registered manager was here; we had regular staff meetings and supervisions. I felt supported."

In August 2014 the registered manager for the Raycroft Unit had taken on the extra responsibility of managing the Alders Residential Home. The care manager told us the registered manager had based himself at the Alders from August 2014. We spoke with the care manager about how effective the management arrangements had been. The care manager told us, "The registered manager told me in December 2014 that he would be applying for dual registration. He said he would be in and out of Raycroft and if I needed anything, he would be there. But it didn't happen how he said it would happen. I have not received any support from the registered manager or provider since becoming care manager."

The care manager explained that when the registered manager was located at the Raycroft Unit his working hours were supernumerary. This meant resources were available through management time to monitor the quality of the service, to develop the team and drive improvement. The care manager told us she had spoken with the registered manager to request some supernumerary hours but it had been refused.

The care manager did not have a job description for her role. We found the service did not have clear lines of responsibility and accountability.

We identified a number of failings during this inspection which had not been identified by the audits carried out by the registered manager. We found the staffing levels at night were not adequate to keep people safe. The provider was unable to demonstrate what analysis and risk assessment had been used to determine sufficient staffing levels.

We also saw that care plans had been audited by the registered manager in December 2014. The audit detailed that care plans were 'all filled in fully'. However we noted care plans had not been updated or changed to identify and manage the significant and increased risk to people's safety.

The registered manager and provider had not taken steps to ensure contractors had undertaken electrical safety tests within the industry recommended timescale. There were shortcomings in the fire safety arrangements. In addition there had been no maintenance work undertaken to secure the building. Suitable arrangements were not in place to manage the risks to the health, safety and welfare of people who lived at the home.

We noted from the care records viewed there had been a number of incidents where people had suffered an injury as a result of a fall at the home. Accident forms we viewed did not outline full details of how the accident happened and what action had been taken. We asked the provider for records that would show an oversight or analysis of the number of accidents at the home. She told us no such records were available. This meant there wasn't an effective system in place to identify where improvements or changes might be required to a person's care or support.

The registered manager and provider did not show the necessary skills and knowledge to manage effectively. They were not fully aware of their responsibilities as the registered person. They did not have appropriate knowledge in relation to the law on Mental Capacity Act and DoLS. A person was being deprived of their liberty without the authorisation of the appropriate supervisory body. There was no mental capacity assessment or best

Inadequate

Is the service well-led?

interest decision in place to identify that it may be in the person's best interests to be cared for in a way that amounts to a deprivation of liberty in order to safeguard them.

Through our observations and discussions with people, we noted that a number of systems to monitor the quality of the service and keep people safe had failed.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify the Commission without delay of the death of a person who was resident at the home. In addition the provider should notify the Commission of other incidents including the serious injury to a person. This is so that we can monitor services effectively and carry out our regulatory responsibilities. We noted during our inspection that deaths and incidents which had resulted in a person receiving treatment at hospital should have been notified to CQC. The registered manager or provider should have submitted these. Our systems showed that we had not received any notifications since 17 November 2013.

This was a breach of regulation 16 of the Care Quality Commission (Registration) Regulations 2009. Notification of death. And regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.