Park Care Limited

Park Cottages

Inspection report

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19 January 2018

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 15 and 19 January 2018 and was unannounced on the first day and announced on the second day. At the last inspection on 22 November 2016 we asked the provider to take action to make improvements around safe care and treatment.

Following the last inspection, we asked the registered provider to complete an action plan to show what they would do and by when to improve the key question safe to at least good. At this inspection we checked to see whether improvements had been made and found the registered provider was not meeting the regulatory requirements relating to consent, safe care and treatment, building safety, good governance and staff training and recruitment.

Park Cottages is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Park Cottages provides accommodation for twelve people with learning disabilities. Park Cottages is in a residential area close to Barnsley and is close to a bus stop and some local amenities. The cottages comprise of one separate unit for three people and two units combined in one building where nine people live.

At the time of our inspection 11 people were using the service on the 15 January 2018 and 12 people were using the service on 19 January 2018

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen; however we found these requirements were not all being met.

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

We found people were not protected from unsafe or unsuitable premises. For example; we found fungi had grown around the carpet under one person's sink due to a water leak. We also found water dripping through the light in the ceiling of the corridor on one unit from a poorly maintained roof. These and other examples of inadequate maintenance presented a risk of harm to people. No action had been recorded to rectify these significant concerns and keep people safe from harm.

Effective systems were not in place to manage and reduce risks to people from inadequate building

maintenance, legionella infection and scalding.

Fire, doors were wedged open and the emergency door closers were not operative on the first day of our inspection. This meant people were not protected in the event of a fire.

People were not protected from the risk of infection because an effective system was not in place to maintain the cleanliness of the home.

Staff told us about occasional incidents between people and two of the care plans we viewed described people's behaviour that may challenge others. No incidents or accidents had been recorded at the service and this made it difficult to demonstrate any learning from these incidents.

Safe recruitment and selection processes were not in place because gaps in employment had not been explored for three staff members and risks related to unsuitable staffing had not been assessed.

We reviewed the systems for the management of medicines and found people received their medicines safely.

Brief risk assessments were in place for people to minimise risks associated with care delivery, some risk assessments lacked detail.

Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse, however no recorded action had been taken by staff to safeguard people from the risks of harm presented by inadequate building safety measures. Sufficient staff were on duty to meet people's assessed needs.

Staff told us they received an induction when they commenced employment with the home, although there was no evidence of this. Staff had received basic training, although no role specific training was evidenced in areas such as learning disability awareness, epilepsy or de-escalation techniques where behaviour may challenge others. Staff competence was not checked. This meant staff may not have the knowledge and skills to support the people who lived at the home.

Staff told us they felt supported and received management supervision in line with the registered provider's policy of twice a year.

We could not be sure people were supported to eat a balanced diet as meals were not recorded and no menu was available. A record of menus was reinstated on the first day of our inspection. Some people told us they did not get a choice of meals but the food was alright.

People were supported to maintain good health and had access to healthcare professionals and services. They were supported and encouraged to have regular health checks and were accompanied by staff to health appointments. The unit manager worked in partnership with community professionals and responded positively to their intervention and advice.

We saw people were offered choice; however, the care plans we looked at did not contain decision specific mental capacity assessments and consent to care was not recorded.

Positive relationships between staff and people who lived at Park Cottages were evident. Staff were caring and supported people in a way that maintained their dignity and privacy, although people's dignity, privacy

and equality was not supported by good standards of building maintenance. People were supported to be as independent as possible throughout their daily lives.

Care plans were in place to provide guidance to staff. People engaged in some social and leisure activities in line with their tastes and interests.

No complaints had been recorded at the home. People told us they had complained about repairs not being completed, but there was no record to confirm this or the action taken in response.

The registered manager was not visible in the service and there was no evidence of oversight or audit by the registered manager. There was no evidence the registered manager had visited the service in 2017.

The registered provider and registered manager had not taken action following our last inspection to improve the safety or governance of the service.

Accurate records were not kept and the building audits completed by the unit manager were ineffective and did not identify or address the significant safety issues we found.

The registered provider had not recorded any checks on the quality and safety of the care provided.

Staff told us they felt supported by the unit manager although the registered manager did not visit the location. The unit manager told us they liaised with the registered manager verbally and we saw occasional supervision was provided by the registered manager at a different location, although no concerns about the quality and safety of the service were recorded by either party.

People who used the service and their representatives were not always asked for their views about the service.

We found breaches in Regulations 11, 12, 15, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Information about CQC regulatory response is added after any appeals have been completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks from poor maintenance had not been assessed and mitigated and fire safety measures were not adequate.

The building was not maintained and managed in a safe way.

Recruitment procedures were not robust.

Medicines were managed in a safe way for people.

Staff had a good understanding of safeguarding people from abuse, however staff did not alert safeguarding authorities about unsafe living conditions.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive service specific training and knowledge was not checked.

People's consent to care and treatment was not always recorded and decision specific mental capacity assessments had not been completed.

People told us the food was alright and they were supported to maintain a balanced diet.

People had access to external health professionals and the unit manager worked well with other services.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff to maintain their privacy and dignity; however staff had not alerted authorities to concerns about poor living conditions, which compromised people's dignity and human rights.

Staff interacted with people in a caring and respectful way.

People were supported to make daily choices and decisions and to maintain and improve their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans contained sufficient and relevant information.

People were involved in activities inside and outside the home in line with their care plans, although some people said support with more outings would be appreciated.

People told us they knew how to complain and that staff were always approachable, although there was no evidence their complaints had been recorded or acted on.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider and registered manager did not have effective oversight of the service. The quality monitoring systems in place did not identify or address the concerns found during this inspection.

The registered provider did not have an effective system in place to improve the quality and safety of the service.

Staff and some people spoke highly of the unit manager.

Park Cottages

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 and 19 January 2018 and was unannounced on the first day. The inspection was conducted by one adult social care inspector on the 15 January 2018 and two adult social care inspectors on the 19 January 2018.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, feedback from the local authority safeguarding team and commissioners. Prior to this inspection we reviewed information of concern about the registered provider and the registered manager and governance of another location they were registered for. The registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Some people who used the service used nonverbal, as well as verbal communication methods. As we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent limited time observing the support people received in communal areas. We spoke with six people who used the service and one relative. We spoke with three support workers, the unit manager, the registered manager, and the registered provider. We received feedback from three community professionals. Two local authority environmental health officers also attended the service with us on 19 January 2018.

During our inspection we spent time looking at four people's care and support records. We also looked at five records relating to staff supervision, training and recruitment, maintenance records and a selection of audits.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe at Park Cottages. One person said, "Yes I feel safe. If there was a fire I would escape through the nearest door to the car park."

At our last inspection on November 2016 we found the registered provider was not meeting the regulations related to safe care and treatment because they had not taken reasonable steps to mitigate risks to people who used the service and appropriate fire safety checks of the building were not in place. At this inspection we found some improvements had been made with fire drills, however the provider was still not meeting the regulations related to safe care and treatment.

We saw where fire doors had a release mechanism these were not operational. A staff member told us the batteries in the mechanism were old. During the inspection the registered provider changed the batteries. However, we noted the fire doors did not release when the smoke alarms in the kitchen sounded, as one door had a wedge holding it open and the floor covering was holding the other door open. We saw between one of the kitchens and a lounge area the fire door did not have an automatic release and was held open with a wedge. Another door also did not have an automatic release and was held open by the carpet.

There were records of weekly fire alarm checks last completed in January 2018; however checks on fire doors had not been recorded which meant faults such as failure in the automatic door closures had not been identified or recorded. The registered provider said they would ensure fire doors were not wedged open in the future. We shared our concerns with the South Yorkshire fire service.

An up to date fire safety risk assessment for the building could not be located. This was completed following our inspection. The above concerns meant appropriate arrangements were not in place to protect people in the event of a fire before our inspection.

Risks to people from inadequate maintenance had not been assessed and mitigated. On the first day of our inspection we found serious concerns regarding the safety of the building. We told the registered provider to take immediate action. The registered provider ensured the work was completed or in progress by the second day of our inspection, however on the second day of our inspection we found further concern relating to health and safety and poor building maintenance.

The unit manager told us no records of regular shower head cleaning to prevent the risk of legionella infection were recorded. The unit manager completed these after the inspection. We asked the unit manager for the legionella risk assessment and they told us they did not have an up to date legionella's risk assessment. This was completed following our inspection.

Effective systems were not in place to reduce the risk of scalding. Each person had a bathing risk assessment in their care files which stated staff would reduce the risk of scalding by checking the temperature of bath water prior to bathing. The unit manager showed us thermometers, which they said staff used, to ensure people were not harmed by scalding water. However no bathing temperatures had been recorded. Water

temperatures at outlets had been checked monthly by maintenance staff until December 2017 and were in the safe range to prevent the risk of scalding. The unit manager told us they would record this in the future.

The registered provider could not provide evidence during our inspection that a gas boiler located in the cupboard in one person's bedroom had been repaired after we had sight of a gas engineer's report from 17 October 2017 that suggested the boiler was not certified as safe for use and there was no evidence this had been remedied. Following our inspection we did not receive this evidence and the registered provider sent us a new gas safety certification for the boiler. We saw evidence of service and inspection records for two other gas boilers for 2017.

People were not always protected from the spread of infections because an effective system of cleaning was not in place. There was an odour in two people's bedrooms. We found one person's mattress was in need of replacing and no mattress checks were recorded. We saw the staff meeting minutes for September 2017 stated '[name of person]'s room to be checked and cleaned daily'. The unit manager told us night staff were responsible for cleaning the person's room and mattress but they had not checked this had been completed daily. The unit manager told us they completed bedroom audits, but was unable to demonstrate they had completed one for this person's bedroom. They told us they would replace the person's mattress immediately.

No cleaner was employed at the home and we found one of the toilets had not been satisfactorily cleaned for some time. The unit manager told us they would ensure the cleaning schedule was adhered to by staff and would audit cleaning and room checks to ensure they had been completed effectively.

Staff told us there had been no falls or incidents at the service and no incidents or accidents had been recorded. Staff told us minor behavioural incidents had occurred and one person described being verbally abused by a peer, when they were in bed at night, which staff confirmed they were aware of and they described the action they had taken to keep the person safe and address the behaviour with the person allegedly responsible. These incidents had not been recorded as incidents or safeguarding concerns. When we discussed this with the registered manager they were not aware of them. This meant the registered manager and registered provider were not keeping an overview of the safety of the service and could not evidence learning from incidents.

The above issues demonstrated effective systems were not in place to reduce risks to people. We concluded this was a breach of Regulation 12 (1) and (2) (a) (b) (d) and 17 (1) and (2) (a) (b) (c) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection we saw water dripping through the light fitting on the ceiling of the corridor on one unit. The carpet below was stained and damp. The wooden ceiling slats were bowing around the light area. This corridor was the only access to the toilet in the unit for three people with learning disabilities. This presented a potential risk of harm from slips and trips and health problems related to damp. The bowing ceiling slats had not been examined by a competent person to assess the risk of the ceiling falling down due to water damage until we requested this on 15 January 2018. The ceiling slats were examined on 19 January 2018 and found not to be at risk of falling down and measures were then taken to dry the ceiling out and ensure it remained safe. This meant the possible risk of harm from the damp ceiling had not been assessed or mitigated prior to our inspection.

The light in the toilet on this unit was not working, which also compromised the safety and dignity of people using the service.

We saw a number of fungi growing from the wet carpet next to the sink in one person's bedroom plus a bracket fungus growing around the leg of the easy chair by the sink. We saw a black substance had exuded from the plug hole of the persons bedroom sink and coated the bottom of the sink. It is unknown what this substance was. The registered provider informed us this had happened previously and was related to a macerator, which had been repaired and taken out of use. This presented a potential risk of harm to health.

None of the maintenance issues we found were recorded in the homes maintenance book as requiring attention. No documentary evidence was provided upon request of action to rectify the issues and mitigate these risks.

The unit manager told us the person's room where we saw the 'fruiting bodies' had been cleaned and checked that morning by a staff member, however there was no evidence of this and the concerns had not been identified, recorded or rectified.

We told the provider to take immediate action to make people safe and by the second day of our inspection improvements had been made.

On the second day of our inspection we found further concerns about building safety, for example; we noted, in the entrance, to one bathroom at the top of the stairs there was a small missing section of the wood flooring. We saw were the bathroom lino and the landing carpet met there was no carpet cover door strip. This meant people may be at risk of harm as this was a trip hazard. The registered provider told us they would repair the flooring immediately. Before the end of the inspection we saw this work had been completed.

The above issues were a breach of regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the building was not maintained and managed in safe way.

We saw general risk assessments were in place and they showed the level of risk. These covered sharps, personal hygiene and food, clinical waste, although we noted these were not dated. The electrical wiring certificate was being completed on the week of our inspection and we saw evidence of portable appliance testing.

We looked at the recruitment process for five staff members and found the process was not robust. We found appropriate checks had been carried out with the Disclosure and Barring Service (DBS). A DBS check provides information about any criminal convictions a person may have. However, we noted one staff members DBS showed a past caution but there was no assessment in place to assess the risk to people who used the service. The unit manager told us they did not know how to do this risk assessment.

In three staff files we looked at a full set of information and documents required as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, were not in place, including a satisfactory written explanation of any gaps in employment. The above issues meant the provider could not be sure they employed fit and proper persons.

We concluded this was a breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had an individual personal emergency evacuation plan (PEEP) in their care records. PEEPs are a record of how each person should be supported if the building needs to be evacuated. Fire drills were completed and staff and people were aware of the procedure to follow.

We asked to look at the safeguarding incident log and found no safeguarding incidents had been recorded at the home. Staff understood how to raise concerns both within their organisation and beyond, should the need arise, to ensure people's rights were protected. One staff member said, "I would report it to my manager and whistle blow if I saw bad practice. If I was concerned about a manager I would go to social services safeguarding." We saw information around the home about reporting abuse and whistleblowing; however staff had not reported building safety concerns to authorities, to protect people from the risk of harm.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place. The service had a system in place to ensure medicines were ordered and delivered before people needed them. Medicines were stored securely in a locked cupboard inside a lockable room.

All of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered with the exception of one boxed medicine, which was one tablet short. Following our inspection the unit manager located the tablet under a desk on the floor of the medicines room and believed it may have fallen out of the foil packet during administration.

We saw staff who were responsible for the administration of medicines had recently had their competency assessed. A weekly count of medicines was completed by staff and medicines were audited monthly by the unit manager or support worker on duty, although the missing tablet had not been identified by the audits.

People and staff told us there were enough staff on duty. We saw appropriate staffing levels on the day of our inspection which meant people's needs were met and people received sufficient support. The registered provider asked staff to do extra shifts in the event of sickness. This meant people were normally supported and cared for by staff who knew them well.

Requires Improvement

Is the service effective?

Our findings

One community professional said, "They engage well with us to meet people's health needs. They raise appropriate concerns if needed, are very kind and advocate well for people."

We found staff were not always supported to gain the skills and knowledge required to meet people's needs effectively. We saw training certificates in each of the five staff files we looked at and these showed the training staff had received. The training covered a range of topics including, dementia awareness, safeguarding, infection control, Mental Capacity Act and Deprivation of Liberty Safeguards, fire safety, health and safety and nutrition and hydration. Although we saw training courses did not cover specific topics that were relevant to the needs of the people who used the service; for example, supporting people with a learning disability, epilepsy awareness and behaviours that may challenge others.

We saw staff training was carried out by an external provider and the training certificates showed staff had completed several topics on the same day. For example, one staff member had completed Dementia awareness, nutrition and hydration, Mental Capacity Act and Deprivation of Liberty Safeguards, infection control, safeguarding and health and safety all on 24 October 2017. We asked the unit manager if they assessed staff knowledge and competency following the completion of the training. They told us they did not carry out staff knowledge checks, which meant staff may not have the skills and knowledge to perform their role. The registered provider told us after the inspection that staff had passed a test before passing each course.

Regular supervision and appraisal of staff is essential to ensure people are provided with the highest standard of care. There was no evidence of individual annual appraisals taking place but the unit manager told us the registered provider did not have a policy for appraisals to be carried out.

The above issues were a breach of Regulation 18(2); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they felt appropriately supported by the unit manager and had occasional supervision and staff meetings. We saw evidence of individual supervisions taking place at the registered providers required intervals of two each year.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We asked the unit manager about the MCA and DoLS and they had some understanding of this, however they felt they had not received sufficient support and guidance from the registered manager. Some staff members we spoke with had a good understanding of the MCA and DoLS. One staff member said, "People who are not on DoLS can understand the risks of going out by themselves. They can do whatever they want to do. They are adults." Another staff member said, "DoLS is there to protect the person because they are vulnerable. [Name of person] doesn't have the capacity to make safe decisions."

One person's care records stated, "[Name of person] has no capacity when it comes to all criteria's of care." We saw one mental capacity assessment and best interest meeting completed by a medical professional in the person s care plan relating to a medical intervention and they were considered to lack mental capacity to make that specific decision. A mental capacity assessment and best interest decision was not recorded for the person in relation to consent to their care plan, medicines administration or the decision to live at the home.

The unit manager showed us they had started to complete a DoLS authorisation application for the person in January 2018. The person had lived at the home for a number of years. The above examples meant people's rights were not always protected in line the Mental Capacity Act.

Staff told us and we saw from records some people who lived at the home were able to go out alone and had the mental capacity to make their own decision to live at the home. We found the care plans we sampled had not been signed by the person to evidence their consent to care.

The above issues were a breach of Regulation 11(1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us meals were planned around the tastes and preferences of people who used the service and staff cooked the main meal of the day with help from people. Most people helped themselves to breakfast, drinks and snacks.

We asked people if they had a choice of meals. One person said, "Not really." A second person said, "No. They don't give you something else if you don't like what's there. You've no chance. I always eat it. It takes a lot to put me off. They vary it though. I don't leave any."

Staff told us they asked people what they wanted to eat in the evening when they returned home from their day time activities. On the first day of our inspection we saw people who wished to, sat together in the dining room to eat their evening meal and everyone had the same meal. One person chose to eat in their room. We heard staff offering the person a choice of meal and they chose an alternative, which they received. On the second day of our inspection we saw people were offered a choice of two meals.

We saw a menu was not displayed. A record of menus or the meals people had eaten was not available for 2017, as the menu book had been mislaid and a new book was reinstated on the first day of our inspection. People were weighed monthly to keep an overview of any changes in their weight and there were no concerns about weight loss. Whether people had eaten well or not was recorded in daily records, but a record of exactly what meals people had eaten had not been kept, which made it difficult to evidence people had a balanced diet. We saw action had been taken when daily records indicated one person's nutritional intake had declined.

No people had any special dietary requirements, but staff said if they did they would cater for their needs.

The service had good relationships with community health services and we saw the advice of professionals was included in people's care plans to help people to achieve good outcomes.

Records showed people had access to external health professionals and we saw this had included GP's, psychiatrists, psychologists, community nurses, chiropodists, dentists and speech and language therapists. This showed people received additional support when required for meeting their care and treatment needs. People also had an up to date hospital passport in their care records to share information if they needed to be admitted to hospital.

Requires Improvement

Is the service caring?

Our findings

People told us most staff were caring. One person said, "Staff are nice." A second person said, "Staff are nice and helpful." A third person said, "They always do look after us. Mine is the best bedroom. Some staff are nice. [name of staff] is too mouthy." We fed this last comment back to the unit manager and we did not see any negative interactions between staff and people.

One community professional said, "The same staff seem to be always here. They are very good at compassionate care."

Staff we spoke with enjoyed working at Park Cottages and supporting people who used the service. One staff member said, "I enjoy every minute of it. I love to be here with people." A second staff member said, "I love care."

Whilst staff interacted with people in a caring way, serious concerns about building safety had not been addressed which did not promote people's rights to a safe environment. We found people's complaints about the unsafe, undignified and uncomfortable environment had not been listened to, recorded or acted on by staff or the registered manager and registered provider. This meant the service did not always promote people's dignity, privacy and human rights.

We observed staff speak to people gently or with appropriate humour and they were kind and compassionate. We asked staff to talk about individuals living in the home and they talked with genuine care and concern and clearly knew people well. We saw people laughing and smiling with staff and we observed warm and positive interactions between them.

One person said, "At 9.30 I go to bed. Staff go to bed then as they have to be up early. I can stay up in my bedroom." We asked the unit manager about this and they said, people could stay up if they wished, however most people were in a routine, which they liked to stick to. People told us they had a choice of clothing, activities or when to have a bath or shower. Staff used speech, gestures, and facial expressions to support people to make choices according to their communication needs. Staff told us they showed people a choice of clothing or food to support them to make every day decisions if their verbal communication was limited.

One staff member said, "With [name of person] we speak in short sentences and use objects of reference." We saw one person used Makaton sign language and staff told us the person used their own system of sounds which they liked to use to communicate choices. Care plans contained details of how to recognise when a person was unhappy or happy using non-verbal cues.

People were well groomed and looked cared for, choosing clothing and accessories in keeping with their personal style. People's individual rooms were personalised to their taste with furniture, personal items, photographs, ornaments and bedding they had chosen. Personalising bedrooms helped staff to get to know people and helped to create a sense of familiarity.

One staff member said, "We ensure privacy and dignity by always knocking on the bedroom doors before going in." Two people had their own bedroom door key; whilst others agreed staff could lock their doors whilst they were out, for security. We saw staff knocked and asked permission before entering people's bedrooms. People's private information was respected and records were kept securely.

One person said, "I cook sometimes. I get my own breakfast; make my own cups of tea. I iron. I help people out." People were encouraged to do things for themselves in their daily life. We saw from records they took part in food shopping, cleaning their own rooms, helping prepare meals and household chores such as loading the dishwasher and laundry. This showed people were encouraged to maintain their independence. Care plans detailed what people could do for themselves and areas where they might need support. One staff member said, "If people are physically able to do something show them how to do it. I use a lot of prompting." This showed us the home tried to encourage and promote people's independence.

Staff told us how they supported people with their emotional needs, for example, supporting a person to open up when they had experienced a loss in order to support them to manage their anger. A second staff member told us how they supporting a person with their private equality and diversity needs after building up a trusting relationship. People told us relatives were welcome to visit any time. This meant people were supported to maintain contact with people who were important to them.

Staff told us they respected people's diverse needs by ensuring they understood the person through their care plan, talking with them and their families and supporting their cultural and lifestyle choices. Care plans recorded any religious, cultural and privacy related needs.

Requires Improvement

Is the service responsive?

Our findings

One relative said, "Yes we have review meetings and they contact us about things. You can phone anytime you like."

Staff said they had read people's care plans and were able to tell us details about individual's care and support needs, as well as information about people's personal preferences, and lives before coming to live at the home. We looked at four people's care plans. Care plans contained a summary about the person plus information covering areas such as mobility, eating, sleep, personal care, behaviour, independent travel, medication and communication. Care plans specific to people's individual needs or medical conditions were also completed and contained information and guidance for staff.

We found care plans explained how people liked to be supported, for example, "[Name of person] likes to lie in at the weekend." And for second person. "I like bubbles in my bath." This was important as some people who used the service were not always able to communicate their preferences. Care plans contained information about people's communication needs in line with the Accessible Information Standard and some information was presented in easy read formats to promote good communication.

Some care plans contained language which may be considered inappropriate, for example, "[Name of person] does like to answer back to other service users and staff." And "[name of person] is medicated for a list of problems." The unit manager said they would address this.

People's care plans were reviewed regularly by the unit manager and updated if the person's needs changed. We did not see any person centred reviews conducted with people by the home, but there were some evidence people were involved in reviews held by day services or arranged by community professionals.

Daily records were kept, detailing what activities the person had undertaken, how they had eaten and slept, care tasks completed and their general mood.

We saw staff at Park Cottages were responsive to people's needs, asking them questions about what they wanted to do and planning future activities. Staff were patient with people and listened to their responses. This meant the choices of people who used the service were respected.

One person said, "I like to get my head in a good book." A second person said, "I go to walking group, dancing. I collect [name of television program] models. I like watching football on TV. I used to watch [name of football team] when they played locally. I don't know why staff don't take me now?"

One relative said, "They are always busy. They took them all on holiday the year before last."

One staff member felt going out more often may benefit some people, although generally staff felt people did enough activities. Some people told us they went out shopping with staff and some people who went

out unsupported went to the library or into town. On the first day of our inspection one person made buns with staff and five people attended day services or work placements. Staff told us and we saw from records how they enabled people to see their families as often as desired. During our inspection we saw staff spent time with people chatting and supported people with their social and emotional needs. This meant people's social, educational and leisure needs were met.

One person said, "I've never had to complain. If I did staff would help." The unit manager told us there had been no complaints. One staff member said, "If any one complained I would report it to the manager. People should be happy and have a good quality of life. We should support people and follow it through." Staff said they would deal with any issues or complaints if they could, would record verbal complaints and inform a manager. People we spoke with told us staff were approachable and they were able to raise concerns, however one person told us their concerns about the building had not been acted on. We found this person's complaint had not been recorded and no action had been taken to rectify it. This meant the registered provider did not always record, address and respond to complaints and feedback from people.

In the care plans we sampled people and their relatives had not discussed preferences and choices for their end of life care, including in relation to their spiritual and cultural needs. Whilst no one was receiving end of life care, some people were living with potentially life limiting conditions. The unit manager said they would discuss this with people to record preferences for the future, to ensure people's wishes were respected and to provide direction for staff. They said one person had a funeral plan in place, which had been arranged by their family.

Inadequate

Is the service well-led?

Our findings

People told us they liked the unit manager. One person said, "[Name of unit manager] is alright. Approachable." A second person said, "[Name of unit manager] is alright. They are the best manager."

At the time of this inspection the service had a registered manager, who was also registered to manage another service run by the same registered provider. The registered manager was based at the other home, although the home had closed the week prior to our inspection. A unit manager was on duty at Park Cottages during the day Monday to Friday.

Staff told us they felt supported by the unit manager, but the registered manager didn't come to the home. One staff member said, "I definitely feel supported by [name of unit manager]". A second staff member said, "Yes I am very much supported. They support me with advice and with my training. The best thing about the home is the smallness. It's like a family. It's lovely."

At our last inspection on 22 November 2016 we found there was a lack of management overview by the registered provider around safety at the home and they were not meeting the regulations related to safe care and treatment. At this inspection we found improvements had not been made.

People were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems in place to monitor the quality and safety of the service provided. None of the maintenance and health and safety concerns we found were recorded in the homes maintenance book as requiring attention. No documentary evidence was provided of action to rectify the issues we found and mitigate the risks. This demonstrated the registered provider was not keeping an overview of the safety of the service.

The unit manager told us the person with a damp carpet and fungi growing from the carpet's room had been cleaned and checked on the morning of our inspection by a staff member, however there was no evidence of this and the concerns had not been identified or rectified. This showed staff compliance with the registered provider's procedures was not monitored.

The registered manager was not in day to day control of the home, for example; they were unaware of concerns about a person when we discussed an incident with them and there was no evidence they visited the home in 2017. They said they were not aware of the repairs that needed to be completed and told us the maintenance person was responsible for these. No checks or audits of the maintenance person's work had been completed.

A monthly tick box audit of the building was signed by the unit manager in August, October and November 2017 and stated, "Adequate cleanliness, safe environment." This audit was ineffective in identifying and addressing the significant concerns we found with cleanliness and the safety of the environment and there was no evidence the audit was checked by the registered manager or the registered provider. No building walk rounds, checks or audits were completed at the home by the registered manager or the registered

provider. This demonstrated the registered manager and the registered provider were not reviewing information to improve quality and safety at the home.

Staff described an incident where the police had been contacted and attended the home, due to alleged criminal activity by a person who used the service; however no incident report had been completed by the registered manager and CQC had not been notified of this incident in line with regulatory requirements. This was a breach of Regulation 18 (2) (e) of the Care Quality commission (Registration) Regulations 2009 (Part 4). As no incident reports had been completed at the service, learning from incidents could not be evidenced.

The registered manager and registered provider did not hold or attend staff meetings. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people. The unit manager held staff meetings and meetings which they called 'staff appraisals', however no action was taken following these meetings to address any issues raised. For example, we saw the notes for August 2017 meeting stated 'at least three bedrooms must be deep cleaned every day and staff suggested doing a bedroom rota'. We noted there was no action plan created from the meeting and when we asked the unit manager if there was a staff rota and if bedrooms were deep cleaned, they told us these had not been put in place. We saw the group 'staff appraisal' notes from the June and August 2017 meetings were identical and no action was recorded from the meetings. This meant the registered provider and registered manager were not seeking feedback from staff, keeping an overview of the service and taking action to improve quality and safety.

People who used the service and their representatives were not always asked for their views about the service. The unit manager told us they held regular resident meetings, although we only saw one meeting in 2017 had been documented. Discussions included day trips, holidays and household chores. There was no other evidence feedback from people using the service was sought or recorded. This meant we could not be sure people's views were taken into account or that they were encouraged to provide feedback on the service provided.

One person told us their concerns had not been acted on. They said, "There is water coming through the roof. There is 'nowt' being done about it. I've told [name of unit manager] and [name of maintenance person] about it. It's like talking to wood." We found this person's complaint had not been recorded and no action had been taken to rectify it. This meant the registered provider did not have an effective system in place to record, address and respond to complaints and feedback from people.

A feedback questionnaire had been given to some relatives to complete when they visited the home and we saw three relatives had completed positive feedback, which was displayed on the notice board in the entrance hall. As these were not dated we did not know how recent this feedback was.

We saw the unit manager had received supervision with the registered manager, although this was very briefly recorded and no follow up of action was evidenced. The unit manager told us they did not have time to attend managers' meetings with other home managers to share good practice and they said they were, "self-taught" in terms of the day to day running of the home. This meant they were not supported by the registered provider to gain the skills and knowledge necessary to perform their role effectively. They said they sometimes attended local authority good practice events and had previously completed nationally recognised team leader and health and social care qualifications.

Staff did not have access to the internet at the home, which made it more difficult to keep up to date with good practice guidance and safety alerts. This meant the management team were not always supported to be up to date with good practice and to promote the best outcomes for people who used the service.

All the above issues demonstrated a breach of regulation 17 (1) and (2)(a)(b)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans and individual people's risk assessments were reviewed regularly by the unit manager and were up to date.

Staff told us they felt supported by the unit manager, and were able to contact a manager by telephone at any time for support. They said they enjoyed working at the home and worked well as a team to support each other. They said the registered manager very rarely visited the home and was not involved in the day to day running of Park Cottages.

The unit manager said they operated an 'open door policy' and people were able to speak to them at any time. Staff we spoke with confirmed this. The unit manager was visible in the home and regularly worked with staff providing support to people who lived there, which meant they had an in-depth knowledge of the needs and preferences of the people they supported.

We found the service worked in partnership with health and social care professionals and there was no delay in involving partners to ensure the wellbeing of the people living at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents CQC had not been notified of all incidents in line with regulatory requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's right were not protected in line the Mental Capacity Act because decision specific mental capacity assessment and best interest decisions were not in place and appropriate DoLS applications had not been made. Care plans were not signed by the relevant person to evidence consent to care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Gaps in employment had not been explored and risks related to unsuitable staffing had not been assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not ensure staff received appropriate training to support people who used the service. Staff appraisals were not completed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate arrangements were not in place to protect people in the event of a fire. Risks to people from inadequate maintenance had not been assessed and mitigated. Effective systems were not in place to reduce the risk of scalding. Effective systems were not in place to reduce the risk of Legionella. People were not always protected from the spread of infections because an effective system of cleaning was not in place. Incidents were not always recorded and so learning from incidents could not be evidenced.

The enforcement action we took:

A notice of proposal to cancel the registration of the registered provider was served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The building was not maintained and managed in safe way.

The enforcement action we took:

A notice of proposal to cancel the registration of the registered provider was served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider and registered manager did not have an effective oversight of the service.

The quality monitoring systems in place did not identify or address the concerns found during this inspection.

The registered provider did not have an effective system in place to improve the quality and safety of the service.

People who used the service and their representatives were not always asked for their views about the service.

Accurate and up to date records were not always kept.

The enforcement action we took:

A notice of proposal to cancel the registration of the registered provider was served.