Care Quality Commission

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Shamrock House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
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 27 September 2018 and 2 October 2018 and was unannounced.

At our previous inspection completed in May 2016, the service was rated as Good. This is the first time the service has been rated Requires Improvement.

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

The home is registered to provide accommodation for up to 17 people whose main need is in relation to their mental health. 16 people received a service at the home during our inspection.

The home had a registered manager. 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. The registered manager was not clear about their roles and responsibilities. They had not submitted all notifications or displayed the rating from the previous inspection in the home as they are required to do as part of the legal registration with the CQC.

Staff had received some training to safeguard people from abuse. Where concerns were raised these were investigated. However, training was not always up to date and staff did not have access to an up to date policy to ensure they followed best practice guidance.

People's needs were assessed and risk assessments were in place. However, where reviews highlighted people were at a high-risk, support plans had not always been updated to ensure information was available to manage the risks and provide people with safe care and support.

Systems and processes in place to maintain and improve the safety of the environment were not effective to ensure the home remained clean and free from hazards and appropriate maintenance carried out.

People were at risk from not receiving their medicines as prescribed. There was no record to evidence staff remained competent or that they had received up to date training to administer people's medicines. The policy and procedure was not up to date or reflective of the service.

Systems and processes in place failed to ensure staff received appropriate supervisions and support to carry out their role. The register manager had signed up to a new training provider but there was no training plan in place to ensure staff remained up to date or competent to carry out their role and meet people's individual needs.

There was a staffing structure in place. However, staff were not always clear about their roles and responsibilities.

Everybody had a care plan. Assessments had been completed to determine people's capacity to understand and consent to their care and support. However, the provider was not always adhering to the Mental Capacity Act which meant people may not always receive care and support that was the least restrictive or in their best interest. There was limited evidence of people being involved in the planning or consenting of their care. Information was not always available to ensure people were supported to improve their lives by monitoring outcomes for independent living skills.

During our inspection we found staff had limited knowledge of the Mental Capacity Act and the Mental Health Act which may impact on how people received safe care and support and have access to appropriate pathways of care to meet their needs. There was no evidence of a record of a health care plan to monitor if the recommended annual health check were completed or actions to support the person to achieve successful outcomes.

Care plans contained details of people's preferences and any specific dietary needs they had. For example, whether they were diabetic, had any allergies or religious needs. However, records did not always include information to support people to maintain a healthy weight.

Care plans included information to ensure staff were informed and respectful of people's cultural and spiritual needs. However, reviews failed to evaluate the care and support provided to ensure records were available for staff to follow to provide people with person centred care and support according to their individual needs.

Where people could be, they were supported to live fulfilled meaningful lives. The provider supported people to obtain skills to take up opportunities of work and attend college. However, where people remained in their rooms, staff were unsure how to encourage and support them to participate in routine social interactions to avoid social isolation.

The registered manager completed checks and audits to maintain and improve the service. However, the systems and processes were not robust and failed to highlight and action the concerns we found during this inspection. There was a lack of oversight at provider level to ensure systems and process used were evaluated for their effectiveness; to maintain and improve the service.

The provider failed to ensure it had robust arrangements to ensure the security, availability, sharing and integrity of confidential data, and records in line with data security standards. Where the registered manager told us, information had been lost there was no evidence of how they had investigated the data loss or where any actions had been implemented to safeguard information because of the data security breaches.

Policies and procedures that were available as guidance for staff were not up to date and not specifically written for the service provided. This meant care and support may not be delivered following up to date and best practice guidance.

The provider ensured staff were selected and recruited safely.

Where people had difficulties with communication this was recorded however, information was not always available in a format they could understand and there was little guidance to support people using other methods.

Staff understood the importance of respecting people's dignity and upholding their right to privacy.

There was information available on how to express concerns and complaints. People were encouraged and supported to raise their concerns and processes were in place to ensure these were responded to.

We found the provider was in breach of six of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff understood signs of abuse to look out for. However, training and guidance was not always up to date to ensure staff were aware of any changes in practice to keep people safe.

Risk assessments for people and checks on the environment were not evaluated to ensure the service was always safe.

Staff were recruited safely. Staff were unclear about their roles and responsibilities.

Is the service effective?

Requires Improvement

The service was not always effective.

Despite assessments to determine people's capacity under the Mental Capacity Act; care and support was not always the least restrictive option or in the person's best interest.

There was limited evidence people had been involved with and consented to their care and support. Staff had limited knowledge of the MCA or the MHA.

Staff did not receive appropriate training and supervision to ensure they remained competent in their role and to provide people with care and support according to their individual needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Systems and processes to ensure confidential information was stored securely were not in line with data protection guidance.

Care plans were not evaluated to ensure staff had access to information to support people with their independence or to identify appropriate pathways of care.

Staff understood the importance of treating people with dignity

and respecting people's privacy. People were treated equally and any diverse needs were recorded and supported where they were known.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were inconsistently evaluated to ensure staff had up to date information to provide everybody with person centred care.

Information was not always available in a format that everybody could understand.

Staff supported people to enjoy activities and opportunities in the community. However, staff were unclear how to support some people who remained in their rooms to avoid social isolation.

Is the service well-led?

Inadequate

The service was not always well-led.

There was a lack of oversight at provider level, to support the registered manager to ensure systems and processes to manage and review the service remained effective to implement and drive the required improvements.

Policies and procedures were not up to date or inclusive of best practice guidance for staff to follow.

There was a lack of oversight to ensure the home remained clean, safe and free from defects.

Care Quality Commission

Shamrock House

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 took place on 27 September 2018 and 2 October 2018 and was unannounced.

On the first day of the inspection the team consisted of two adult social care inspectors and one Specialist Adviser (SPA). The specialist adviser was a specialist in the Mental Health Act and with people living with mental health. The second day of the inspection was completed by one adult social care inspector.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to tell us about within required timescales.

We sought feedback from local authority commissioning teams and Healthwatch. Healthwatch is the consumer champion for health and social care.

During the inspection, we spoke with the registered manager, and five members of staff. We spoke with five people in receipt of a service, one relative and a visiting health professional, to seek their views.

We had a look around the home and looked in people's rooms with their permission. We observed staff administering people's medicine and completed observations of staff interactions with people throughout the day.

We reviewed a range of records. This included five people's care records containing care planning

documentation and daily records. We also viewed the records for five staff relating to their recruitment, supervision and appraisal. We reviewed the process used to manage staff training. We viewed records relating to the management of the service, including audit checks, surveys, quality assurance and the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with staff and from abuse at the home. One person told us, "Yes I do, (feel safe) I get looked after really well, especially by the day staff." Staff could describe the types of abuse to look out for and how to raise any concerns for further investigation. Staff had received some training in safeguarding. However, there were no records in place to confirm training was kept up to date to ensure staff had the latest guidance and always followed best practice. We were shown a safeguarding policy that was used as guidance by staff but this was dated November 2012. The policy had not been updated in line with the local authority procedure. This meant staff may not always respond to concerns appropriately, following agreed safeguarding guidance, to ensure people were kept free from the risks of abuse. One staff member said, "I think people are safe; we report any concerns and they are investigated. Training could be improved so we are kept up to date."

The provider did not ensure people always received safe care and support. Assessments of care and support had been completed and where risks were identified the provider had competed risk assessments. However, where reviews of risks had been completed as people's needs changed, they were not always dated and where risks remained high there was no evidence they had been re-evaluated to keep people safe. For example, a recent review of one care plan recorded evidence the person was smoking in their room. However, there was no evaluation of the risk or implementation of an associated support plan to keep everybody safe.

Care records we looked at did not include a positive behaviour support (PBS) plan. Behaviours that challenge usually happen for a reason and may be the person's only way of communicating an unmet need. PBS helps providers understand the reason for the behaviour so they can better meet people's needs, enhance their quality of life and reduce the likelihood that the behaviour will happen. However, one care plan recorded a person showed challenging behaviour that put themselves and others at risk of harm. The care plan recorded staff should escort the person back to their room and that they were prescribed a medication to reduce their risk of aggression. We checked and the medicine prescribed was for anxiety and not aggression. There was no PBS plan in place to ensure the person's needs were met and to manage their behaviour to reduce the risk of harm to themselves or others.

People were at risk from avoidable harm from the use of bedrails. For example, from entrapment and faulty equipment. Where people had been assessed as requiring bed rails, routine checks on the equipment used to ensure it remained safe and suitable for use had not been completed. Assessments recorded people with bed rails showed signs of confusion. There was no evidence this information was discussed with people. This meant that people were not always supported to remain safe and without undue restrictions in place. We discussed the implementation of additional records with the registered manager who told us they would seek guidance from the Health and Safety Executive and implement the required systems and processes to assure people's safety.

Systems and processes failed to maintain, and ensure the home environment remained safe. We found old and broken fixtures, fittings, and furniture around the home and in people's rooms that was not recorded or

actioned to ensure the home remained a safe place for people to live. Records were not maintained or checked to ensure any associated actions were completed in a timely manner. Where flooring required additional fixings, these were not secure and this meant people were at risk from trips. A fire extinguisher was not secured to a wall as required for quick access, in an emergency. Maintenance around the home that included gated access to the property, light bulb checks, painting and decorating, and general upkeep was not managed to ensure a safe environment. The registered manager implemented some corrective actions which included securing of the flooring, during the second day of our inspection.

A cleaner was employed and a schedule of cleaning was completed as part of infection control practice. However, routine cleanliness of bathrooms and toilets was not checked or recorded and we found areas that were not clean, maintained or free from mould.

Other certified checks, where required, were not well managed. Checks were completed to ensure water supplies were free from Legionella's disease, (a waterborne virus). However, there was no robust recording to ensure all checks were completed within the required timescales. For example, a five yearly electric safety certificate had been due in June 2018. This was being completed at the time of the inspection. This meant the provider was unable to provide assurances the home and all equipment was always safe for everybody.

Information was not always available, and training was not up to date to ensure staff and other responders had the information available to safely evacuate people. People had Personal Emergency Evacuation Plans (PEEPs) in place. A PEEP provides information regarding the level of support people required should they need to be evacuated in an emergency. PEEP's were not easily accessible for reference should there be an emergency evacuation, and contained only generic information. Despite a review of one PEEP in July 2018, information still stated the person may not react to the fire alarm. There was no record of how staff should support or alert the person to safely evacuate the home in the event of fire. Staff monthly fire drills were completed but only recorded up to June 2018. We were unable to check which staff had completed fire training and awareness because new staff had not been added to the list. The registered manager told us, "I do try to carry out fire drills two monthly. The date of our next fire drill will be 12 October 2018."

People were at risk from not receiving their medicines as prescribed. We observed medicines were stored according to manufacturer's guidance. Records of administration were completed after staff observed people taking their medicines. However, guidance to ensure one person took their medicine 'as required' were missing. This meant the person may not receive their medicines as prescribed to remain safe and well. Staff did not have access to an up to date policy and procedure that ensured they followed national best practice guidance when managing and administering people's medicines. Medicine audits to check the administration and management of medicines were completed. However, these were not detailed and did not include evidence that actions were completed where this was required.

The above findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a systematic approach, for example, a dependency tool, to determine the number of staff or range of skills required to meet people's individual needs and to always keep them safe. On the first day of our inspection we were greeted by two staff; one was employed to work in the kitchen the other was a cleaner. They were supported by a care worker who had just returned from a period of absence and an apprentice care worker. Despite a staffing structure, staff were unclear when discussing their roles and responsibilities, or if there was a senior on duty in the absence of the registered manager. A staff member told us, "I should be on holiday but they are short staffed so I agreed to come in." A senior-in-charge and the registered manager attended the inspection later in the day. Despite also being on holiday the registered

manager advised us that due to a lack of oversight, staff had booked block leave at the same time resulting in a short fall. They told us key staff had recently left. They said, "We have a couple of staff we can rely on to come in so we don't use agency."

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

The provider ensured staff were selected and recruited safely. Checks were completed before staff began work. This included obtaining a minimum of two references, and the completion of a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevents unsuitable people from working with people who require care.

There was a system and process to record accidents and incidents. However, there was no evidence to show that the provider had evaluated incidents. The registered manager told us, "We don't get many accidents and we discuss them at team handovers; staff are aware of the outcomes." Staff confirmed these were discussed during staff meetings to help reduce any similar events.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection, we found the provider was not always working within the principles of the MCA. Records confirmed assessments were completed to ensure people could make informed decisions and choices and where they were assessed as not having capacity referrals had been made to the local authority for further assessments for a DoLS. However, restrictions were being used where people assessed as having capacity, had not agreed to them.

Records confirmed people had been assessed as having capacity to agree to bed rails. However, their consent to the use of bed rails was not recorded and one person told us they did not agree or want bed rails in place. The provider had failed to support the person with their decision. A member of staff said, "They need bed rails to ensure they do not fall out of bed due to reduced mobility, and they (bed rails) help us to manage their incontinence." They continued, "They don't understand why they have to have bed rails; they do not want them." No further MCA or best interest meetings had been completed or recorded to ensure the restrictions were both legal and the least restrictive options.

We discussed our concerns with the registered manager who told us they didn't think the person had the capacity to consent to the use of bed rails and they confirmed no further assessments had been completed to support this in line with the MCA.

There was no evidence in the care plans we reviewed that people understood and had provided their written consent to their care and support. Documents were in place to assess people's capacity to take their own medicines. However, outcomes of the assessments were not clearly recorded and people had not signed their consent. Some people lived in shared rooms. There were no records in place to assess the associated risks or to assess people's capacity for people to agree to sharing a room.

Staff who we spoke with did not have a clear understanding of the MCA or the Mental Health Act (MHA). The provider did not have an up to date MCA policy and procedure for staff to follow to ensure staff obtained consent to care and support following current legislation and guidance. This meant people may have unreasonable restrictions in place resulting in them being illegally deprived of their liberty.

The above findings were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
The registered manager was responsive to our feedback and the shortfalls we evidenced. Because of our

feedback the registered manager submitted an application to the local authority safeguarding team for an urgent DoLS assessment regarding the person's capacity to agree to the use of bed rails. They told us they would seek people's consent and added a form to record this information.

New staff received an induction to their role and to the home. However, this did not include assessments of staff competency, to identify any further training needs. Staff told us they received some training but there was no system in place to review and plan staff learning to ensure they had the appropriate up to date skills to carry out their role and meet people's individual needs. One staff member told us, "People's needs are changing and some people require more assistance to mobilise. We have a hoist but the only training has been by the people who brought the hoist to the home. We haven't had any moving and handling practical training." We checked the training matrix. Out of twenty staff on the matrix, five were evidenced as receiving some moving and handling of people training in 2011 and 8 staff had received awareness of moving and handling training in 2014. All staff training in moving and handling of people had expired. After the inspection the provider told us they had scheduled training for moving and handling and first aid for the 07 December 2018.

During our inspection we found staff had limited knowledge of the MCA or the MHA. Staff training for MCA and MHA was recorded on the training matrix. Out of twenty staff eight had received some training in MHA in 2013 and two had received training in 2006. Three people had received some training on the MCA and DoLS in 2009. All associated training had expired and no further training was scheduled. A visiting health professional told us, "Staff would benefit from mental health training, to better understand different diagnosis, understand how this affects behaviour and learn the best way to respond to this behaviour."

We were unable to evidence all staff responsible for people's medicines had received appropriate up to date training or at least annual checks to determine their competency to do so. We discussed training with the registered manager who told us, "We have signed up to a new training provider which means a new programme of training will be available for staff to complete." The provider told us they were implementing the care certificate for all staff to complete. The care certificate is a set of basic standards in providing care and support, for staff to adhere to in their daily role. After the inspection the provider told us eleven staff gained certificates for Safe Handling of Medication in July 2018 and that more were ready to be sent away for marking.

Staff received an annual appraisal. However, they did not receive regular, appropriate and professional supervision of their ongoing performance in their role. Staff told us, "We have handover sessions where we discuss people's needs between us" and "We have a meeting now and again with [registered managers name]. It's quite an informal process and never takes very long." There was no information to record detailed discussions where staff had been able to input their aspirations or to record what the staff member was doing well or areas for improvement. The registered manager showed us an action plan to address the concerns, which recorded, 'All staff will be sent invitations to come in for a professional supervision. This will be to reiterate key points and highlight areas where improvements need to be made. Roles will be clarified and responsibilities outlined.'

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

In the care records we looked at staff recorded people's weights every month. However, no further evaluation tools were used. For example, to identify people who were malnourished, at risk of malnutrition (under nutrition) or obese. One care plan evidenced a monthly weight monitoring sheet which showed the person had increased their weight by five stones over a five-year period. There was no record to assess if the

person's weight gain was healthy. For example, using the body mass index (BMI) and no guidance from a dietician. Obesity is a major physical health risk, not recording BMI`s could prevent people accessing appropriate support to manage their weight and improve their physical health.

Information to record how people were supported to receive the care required to meet their individual assessed needs was not evidenced in all the records we looked at. Where people had a diagnosis of severe mental health illness there was no evidence of continued support or input from the community mental health team or social workers to ensure people's needs were holistically assessed and their care and support was delivered in line with legislation to achieve effective outcomes. After the inspection the provider told us, 'All individuals have access to a Community Psychiatric Nurse (CPN) through referral from GPs. Currently only those who have depot injections see a CPN regularly.' When asked, staff did not appear to have the skills or knowledge to manage the complexities of people's mental health needs. There was no formal process to identify people's status under the Mental Health Act (MHA), and most importantly to ascertain if they were having their care met under the associated legal requirements of Section 117 aftercare of the MHA.

The National Institute for Health and Care Excellence (NICE) recommends in its guidance that people with serious mental illness should receive annual physical health checks. A consultant psychiatrist or a trained specialist with experience in 'at-risk mental states' should carry out the assessment. There was no recorded evidence of a health care plan to monitor if the recommended annual health checks were completed. Actions required to support the person to achieve successful outcomes were also not recorded. The registered manager told us, "All service users (people) have regular health checks and have their medication reviewed by GPs; feedback is not always passed on to the home. Those on depot injections (medication to manage their illness) have medication reviewed there also." This meant staff did not have access to clear records of guidance to provide people with person centred care to help them manage their progress. After the inspection the provider told us they had completed eleven mental health related checks beginning in January 2018 and continuing into February.

The above findings were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had an accessible entrance and outside space for people with reduced mobility who required wheelchairs to mobilise. Where people had reduced mobility, they were located on the ground floor of the home/service. The corridors and doorways were narrow and staff were observed to have difficulty in moving people in wheelchairs. There was no stair lift and people with reduced mobility who could not access the stairs had access to a shower room only without a bath. There were a further two bathrooms on the first and second floor. However, there was no lift and the bathrooms were not suitable for people with disabilities. The provider told us after the inspection, they had completed a risk assessment to install a stair lift which found the home was deemed unsuitable. The home would benefit from improvements including decoration and signage to enable people to navigate more easily. Because of our feedback the registered manager recorded on an action plan, 'Initial report given to [Provider name] to formulate their own action plan re decorating and budget.'

Care plans included information to help staff provide people with healthy eating options. People gave us positive feedback about meal times and the food provided. One person said, "The food is nice. They have a board up for what is on offer in the week." Where people had any dietary requirements for example, due to diabetes or religious preferences, these were recorded and catered for. People were supported to maintain their daily health needs with access to their local GP, dentist and where required they were supported by the district nurse. One person said, "I can see a doctor whenever I need to; I make my own appointments."

Requires Improvement

Is the service caring?

Our findings

People living at the home told us they felt staff were caring. Comments included, "If it wasn't for the staff I wouldn't be here now, they take really good care of me" and "They (staff) bend over backwards to help you." When asked, staff told us they thought people were well cared for and this was a priority of their role.

People we spoke with were aware they had a care plan. One person said, "I have a care plan; it's in the office. It's discussed about once a year; not often." Care plans included a pre-assessment by the provider prior to admission to the home. However, there was little evidence to show that people had been consulted with on a regular basis as part of the ongoing evaluation of their care and support. There was no evidence in the care records we looked at, of outcome measures in monitoring independent daily living skills or how the provider supported people to achieve effective outcomes to live as independently as possible.

People had been allocated a key worker. The key worker's role was to ensure the person was supported with any daily living requirements for example, to ensure they had personal care items available and to access any health appointments they required. Care plans included a key worker time sheet which recorded that at least two hours per week should be spent with the person, one to one. However, there was no evidence or records of how time was scheduled to allow the staff allocated time to listen to people, answer their questions, provide information, and involve people in decisions about their care.

The registered manager showed us an action plan they intended to implement to ensure people were consulted with as part of monthly evaluations or when their needs changed.

People's records were not always stored securely. The registered manager discussed how they had stored people's personal, and other information associated with the running of the home on a computer and an associated backup device but had lost the data stored electronically. There were no records of the actions taken by the provider to ensure they had complied with the Data Protection Act. Staff understood the need to maintain people's confidentiality and told us they would only share information discussed if the person was at risk of harm, abuse or required medical attention.

We observed staff knew people well and had built friendly relations with them. People were addressed by the name they wished to be called and it was clear staff were aware of people's preferences. A staff member said, "[Person's name] chooses to stay in their room, it's their safe place; we check on them to make sure they are ok." Another staff member said, "We support people with how they choose to be supported; it's their home after all."

Staff could discuss how they maintained and respected people's privacy and dignity. They told us, "During personal care we always encourage people to assist with bathing, have towels ready and we make sure we close doors to keep everything private." We observed staff did not always knock on people's doors before entering their room but people did not appear to mind. Where staff did knock they waited for a response from the person before entering. A member of staff said, "We normally knock but people often leave their doors open so we can just go in and have a chat or keep an eye on them as we are passing."

Staff told us they understood the need to treat everybody equally without discrimination. A staff member said, "There is nobody living here with any specific needs under the equality act but if we were aware we would ensure those needs would be met." Where people at the home were in a relationship the provider ensured they were supported to maintain this and accommodation was provided to facilitate their lives together. Where people had any religious needs, they were supported with their faith. The registered manger confirmed a pastor visited one person each week and another person attended religious services each weekend.

Requires Improvement

Is the service responsive?

Our findings

Everybody who received a service had a care plan in place. However, information was not consistently recorded or person centred. Care plans we looked at did not consistently record that people had been consulted with about their care and support or that they understood and provided their consent. Monthly reviews failed to evaluate the care and support for its effectiveness or to record additional actions where improvements for the person had been identified.

A care plan recorded one person did not change their clothes. There was limited information for staff to manage this with the person. The progress notes in the review simply recorded 'No change`. Another care plan recorded a person was incontinent. There was no evidence of reasons for incontinence for example, physical, mental health, and no referral to GP for incontinence services. The progress notes in an undated review recorded 'still incontinent of urine on occasions, has had instances of public urination.' This meant information to support people on an individual basis was not person centred or tailored to people's individual needs.

Where people had a diagnosis of severe mental health illness, care plans did not include detailed information to ensure people's needs were met by evaluating the care and support provided. One care plan recorded a person 'suffered from paranoid schizophrenia, experiences auditory hallucinations, and will respond to them`. There was no further evidence on the extent and content of the hallucinations, if they distressed the person, how they could be managed or if they could pose a risk to others or themselves. There was limited guidance for staff to follow in the care plan to provide responsive, person centred care and no evidence of the person's involvement.

Information was not always available in a format that everybody could understand. One care plan recorded a person needed help with reading and writing. The care plan was written in standard text and there was no evidence of the person's involvement. Information recorded the person should be encouraged to take up literacy classes again but stated the person did not wish to attend courses. There was no other information to provide staff with guidance on alternative methods of communicating with the person. For example, there was no evidence of use of Makaton (pictures) or the use of electronic tablets to enhance communication or using large and coloured print. However, a staff member said, "[Person's name] is able to express their views and opinions."

People were supported to maintain individual and family relationships. Where people choose to they remained in their rooms and staff routinely checked on their wellbeing. However, staff we spoke with were unsure how to encourage and support some people to engage with activities, enjoy trips out or participate in routine social interactions to avoid social isolation. A staff member said, "[Person's name] chooses to stay in their room. They are fearful of coming out. We have tried to encourage them to participate but they don't want to; there is nothing else we can do."

The above findings were in breach of Regulation 9: Person centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff gave us one care plan which they told us had been updated to a new format. The care plan was in a very different format to the other care plans we reviewed. We found information was detailed, included a photograph of the person and was person centred. Information was completed on the persons background, their skills and interests and likes/dislikes. There was information on how much the person could do on their own and areas that they required support with. Information was recorded for staff to follow to help the person with a recovery focus to enable the person's wellbeing. However, the member of staff responsible for the revised plan was leaving the service and the registered manager did not have a clear plan in place to update all other records to this standard.

Records included the Herbert protocol. The Herbert protocol is a national scheme with police and other agencies which encourages providers to compile useful information which could be used in the event a vulnerable person goes missing.

Where people could, they were encouraged and supported to access education, communal groups and go on trips. People had enjoyed a trip to a safari park and staff discussed taking a person to the sea side. One person spent the working week working for a gardening organisation. They told us they were picked up each morning and completed work around the area. People were supported to enjoy activates of their choosing. One person said, "I was invited to sing and did karaoke." Another person said, "Sometimes singers come here. We have good Christmas parties and celebrate at other times as well." The outside seating area was planted with colourful plants providing a tranquil area for people to enjoy. One person told us, "We got the plants from the garden centre and planted them up; they look lovely."

At the time of the inspection the provider told us there had been no complaints about the service. A member of staff said, "People will soon tell you if they're not happy. We can usually sort small concerns out straight away. We don't really get complaints but if we did they would go to the manager for investigation." The provider had a complaints policy and procedure and guidance was available to help people raise their concerns.

Inadequate

Is the service well-led?

Our findings

There was a manager employed at the service who was registered with the CQC. There was a staffing structure in place. Staff spoke positively about the registered manager. However, staff were not clear about their roles and responsibilities. Staff told us the registered manager was approachable and that they received good support when they required it. They told us the service provided people with good care but that the home required updating.

The registered manager was responsible for upholding the legal requirements and for the day to day running of the home and received some limited support from the provider. The registered manager was not clear about their legal responsibilities under their registration with the CQC. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. We checked and found the registered manager had not notified the CQC of all important events. For example, we had not been notified about outcomes of applications by the provider to assess people for a deprivation of their liberty, where one person had left the service due to challenging behaviour or where information was lost. We are dealing with this matter outside of the inspection process.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had failed to display the previous inspection ratings as they are required to do in the home. They had failed to seek advice on how to obtain the required information and were unaware of their responsibility to do so. We are dealing with this matter outside of the inspection process.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to ensure they had appropriate arrangements to ensure the security, availability, sharing and integrity of confidential data, and records and data management systems, was in line with data security standards. The registered manager told us they kept electronic records, policies and procedures on their personal laptop. They told us information had been lost and back up information had been corrupted. There was no evidence of how the provider had investigated the data loss or where any actions had been implemented to safeguard information because of the data security breaches.

Information was not always maintained securely to ensure only people who needed to had access. The registered manager told us they had a book to record any maintenance requirements and a book to record personal daily information where people's needs changed. However, staff were recording both sets of information in one book. This meant people's confidential records may be at risk from people seeing the information who were not required to do so.

We asked for a variety of records and documents during our inspection that included policies and procedures and other checks completed by the provider to maintain and improve standards. However, these records were not always up to date, stored securely or available. For example, policies and procedures

were not up to date and not specifically written for the service provided.

Checks and audits failed to always ensure people always received person centred care to achieve good outcomes or that care and support was in their best interest or least restrictive options. The provider told us they reviewed people's records monthly or as their needs changed. However, these checks failed to ensure records were always accurate, complete and contemporaneous in respect of each person. Checks did not always include peoples consent or agreement to decisions taken in relation to the care and support provided.

Systems and processes to maintain and improve standards around the home were not effective and failed to identify the issues we found during our inspection. There was no oversight to ensure checks for example, medicine audits, infection control audits and routine maintenance were completed. Where concerns were recorded there was no system to ensure any required actions were implemented in a timely way to ensure the home remained compliant.

There was no oversight to ensure sufficient numbers of skilled staff were available to always meet people's needs. The provider completed internal checks and had a process to record training completed by staff. However, the records were not up to date and recorded 167 training records had expired. The registered manager had signed up to a new training provider. However, there was no record of planned or refresher training where this was required or how the provider intended to ensure staff had the appropriate skills and knowledge to meet people's individual needs. The checks did not include records to validate staff were competent in their roles. The registered manager told us they completed visual observations of staff carrying out their roles but there was no system or process to record the checks or to ensure actions were completed where staff were deemed not competent. This meant the quality assurance checks were not robust and failed to ensure training was always up to date and appropriate to meet people's needs.

The provider did not have effective systems and processes in place to continually evaluate and seek to improve governance and auditing practice. The registered manager told us all concerns were dealt with at management level and outcomes were not always shared. We looked at a range of quality monitoring logs which were completed by management. However, there was no oversight by the provider to evaluate this information. There was no plan of action to improve other areas of the service and no input from the provider to drive the required changes forward. We were shown an annual service report and business plan but this had not been updated since 2015.

The provider sought the views of individuals connected with the home. People living at the home told us they had resident's meetings where they could raise any concerns and staff told us they were asked for feedback and had occasional staff meetings. A staff member said, "We are always asked for our input to the Christmas party; they are always a good event." However, there was no clear evidence of how feedback was evaluated to help improve the service or identify areas of the service that were performing well.

The above findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

We discussed the findings of the inspection with the registered manager. It was clear the registered manager and staff were passionate about improving the service and some remedial actions were implemented during our inspection. The registered manager provided the CQC with a response to our initial feedback and confirmed, 'Some things we have implemented already, some are to do and some will be to implement, or improve.' However, further actions were still required. After the inspection the provider told us they had purchased the full range of policies and procedures, audit tools, care plan tools and templates, tailor made

to the home and that this was now accessible to staff.

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 9 HSCA RA Regulations 2014 Person-centred care The registered manager failed to ensure they had done everything reasonably practicable to make sure that people who use the service received person centred care and support that was appropriate, met their needs and reflected their personal preferences. There was minimal evidence of people's involvement in their care and support plan to evidence any support provided to help people understand and make informed decisions about their care and treatment options, including the extent to which they may wish to manage these options themselves. The registered manager did not always take into account people's capacity and ability to consent, or ensure that either they, or a person lawfully acting on their behalf, was involved in the planning, management and review of their care and treatment within the requirements of the Mental Capacity Act 2005, which includes the duty to consult others such as carers, families and/or advocates where appropriate. Regulation 9 (1) (3)(a)(b)(c)(d)(e)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager failed to ensure people had been consulted with and had provided their consent to care and support provided or

	that staff had acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always mitigated and people did not always receive care and treatment which was appropriate to their needs. Systems and processes in place failed to ensure that the premises and equipment used by the service provider were always clean and safe. Systems and processes failed to assure the proper and safe management of medicines. Regulation 12(2)(a)(b)(d)(e)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems and processes failed to ensure sufficient skilled staff were in post and that staff received such appropriate support, training, professional development, and supervision as is necessary to enable them to carry out the duties they are employed to perform, and meet people's individual needs. Regulation 18 (1) (2)(a)

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager failed to notify the CQC of all incidents that affect the health, safety and welfare of people who use services. This included any event which prevents, or appears to the service provider to be likely to threaten to prevent, the service provider's ability to continue to carry on the regulated activity safely, or in accordance with the registration requirements. This included damage caused to the home and loss of information. The registered manager failed to notify the CQC regarding outcomes where applications had been submitted to the supervisory body to deprive people of their liberty including the outcomes of those applications. (DoLS). 18 (2)(g) 4(A)(a) (B)(a)(b)(c)(d) 5(a)(b)(e)

The enforcement action we took:

Issue of fixed penalty notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Inadequate governance policy and procedures and insufficient oversight and evaluation at provider level meant the provider failed to ensure quality assurance and auditing systems or processes were fit for the purpose; to assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The systems and processes failed to assess, monitor and mitigate any risks relating the health, safety and welfare of people using services

	and others. In addition, the provider failed to ensure they securely maintained accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity. Processes in place to seek and act on feedback from people using the service, those acting on their behalf, staff and other stakeholders, was not effective or evaluated to continually drive improvement. Regulation 17 (1) (2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered manager had failed to display the most recent rating by the CQC that relates to the service provider's performance at those premises. 20(A) (3)

The enforcement action we took:

Fixed Penalty Notice