Cumbria County Council

# Petteril House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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? | **Requires Improvement** |

# Summary of findings

## Overall summary

The inspection took place on 11 and 17 July 2018 and was unannounced.

At our last inspection of this service, the provider was meeting the legal requirements and the last rating was Good.

Petteril 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.

Petteril House is registered to accommodate up to 37 people across three separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia. Accommodation is provided over two floors. At the time of our inspection there were 24 people living at the home.

The service 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 service had ineffective systems in place to ensure there were sufficient numbers of staff on duty at the home. This was of particular concern at night when, at times only two members of staff were on duty for the whole of the home.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

The service did not effectively monitor and manage the risks associated with poor nutrition and hydration. Support with eating and drinking was inconsistently provided and records relating to nutrition and hydration were poorly maintained.

The service had systems in place to help monitor the quality and safety of the service. The systems were not always effective in identifying where improvements should be made.

These are breaches of the Regulations.

The care records that we reviewed did not always reflect the most up to date and accurate information about people's care and support needs. There were protocols in place to help ensure people were supported appropriately at the end of their life.

Medicines were not always managed safely. Gaps in records meant that people either did not receive their medicines as their doctor had intended or that staff had not recorded the administration of some medicines correctly.

Written information about other support services that people and their relatives could access was available. However, these formats would not meet the communication needs of some of the people using this service. We have made a recommendation about involving people in decisions about their care.

There was little information recorded about people's hobbies and interests. Staff organised activities such as bingo and quizzes on a day to day basis, if they had the time. Care and support planning did not take account of the social needs of people using this service.

We have made a recommendation about supporting people to follow their interests and participate in relevant social activities.

The provider had systems in place to help ensure people were protected from the risks of abuse. Staff were recruited safely and provided with training to help them understand the actions they should take if they suspected someone was being abused.

Staff employed at the service had access to, and attended training programmes to help keep their skills and knowledge up to date. Staff attended team meetings and supervisions, which provided a platform for them to discuss their work and performance.

Staff followed good infection control practices. The service ensured that safety checks at the home and maintenance of equipment had been regularly carried out.

Staff attended to people's needs in a friendly and kind manner. People were supported with respect and dignity and staff ensured support was carried out in private. We received positive comments about the way in which staff cared for and supported the people who lived at this home.

People had access to health and social care professionals when they needed them. The service provided opportunities for people, their friends and relatives to be involved with, and comment on the operation of the home.

We found five breaches of the Regulations. These related to obtaining lawful consent, nutrition, staffing levels, notifications and governance of the service.

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 home did not always have enough staff on duty to meet the needs of people living at the home.

Individual care records were not always accurately maintained.

Medicines were mostly managed safely. There were gaps in information and record keeping about 'when required' medicines and topical ointments and creams.

The provider had systems in place to help ensure people were protected from the risks of abuse.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were not always effectively supported with their nutritional needs. This placed them at risk of receiving inadequate food and drink, which potentially impacted on their health and wellbeing.

The service did not consistently follow the principles of the Mental Capacity Act 2005.

Staff at the service were provided with training and supervision to help them understand and fulfil their roles and responsibilities.

People who used the service had access to health and social care professionals when requested or needed.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff treated people with kindness and respect. They were mindful of the need for privacy and dignity.

Staff were usually sensitive to people's needs and recognised when support was needed.

Information was not easily accessible to some of the people who lived at the service.

We were not assured that people consistently received a high quality compassionate service.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans, assessments and reviews had not been kept up to date so that they reflected people's personal needs, choices, leisure and social interests.

There were limited opportunities at the home for people to actively engage in meaningful leisure and social events.

The provider had a complaints process in place that people were able to access.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

The service had policies, procedures and auditing systems to help monitor the quality and safety of the service.

The governance systems were not always effectively applied and failed to identify areas where improvements should be made.

People living at the home were provided with opportunities to comment on the quality and operation of the home. Their comments had not always been acted upon, particularly in relation to activities.

# Petteril 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.

This inspection took place on 11 and 17 July 2018 and was unannounced.

The inspection team consisted of one adult social care inspector and a specialist advisor whose area of expertise was nutrition.

Before we visited the service, we checked the information we held about this service and the service provider, for example, inspection history, complaints and statutory notifications. A notification is record about important events which the service is required to send to us by law. We contacted health and social care professionals involved in caring for people who used the service, including community nurses, commissioners and safeguarding staff. Information provided by these professionals was used to inform the inspection. We also contacted Healthwatch, but they did not hold any information about Petteril House.

During our inspection, we spoke with four people who used the service and three family members. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us.

We also spoke with the registered manager, operations manager, two supervisors, four care assistants, the cook and two of the domestic staff. We observed staff practices, looked at the care records of six people who used the service, staff recruitment, training and supervision files and records associated with the management of the service.

We did not ask the provider to complete a Provider Information Return (PIR) at this inspection. This is information we usually 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

Following the inspection, we asked the provider to send us information about their staffing levels and how these were calculated to meet the needs of people using the service. We also asked the provider to send us various policies and procedures in relation to the running of the service. The provider sent us this information as requested.

Requires Improvement

# Is the service safe?

## Our findings

People using the service were not always safe. We noticed that call bells often rang for 5 to 10 minutes before they were answered. The registered manager told us that there were no systems in place to check the response times to call bells. This made it difficult to monitor whether people had their needs attended to, including times where people had suffered an accident, in a timely manner.

One person who lived at the home told us; "I am well looked after here and the girls (staff) come when I ring my bell." Another person said, "The staff response to my call bell varies. Sometimes I can wait up to 20 minutes for them to come. This is particularly bad if I need help during mealtimes. There are only two staff available. Serving meals and answering call bells it's a lot to do." They added, "Sometimes one carer will answer the bell initially and then a different one will come a bit later to help me."

The staff we spoke with also told us that there were times when they felt there were not enough staff on duty, particularly on the late shift. One member of staff said, "I come in some mornings and there are loads of us on duty. I have gone home and come back later to cover the late shift to try and even things out a bit."

We looked at how the registered manager worked out how many staff should be on duty at any one time. The system was based on the number of people using the service rather than their assessed care needs. We spoke with the registered manager about this at the inspection. We asked them to send us more information about people's needs to help us understand how staffing levels were calculated. We looked at this information alongside the staff rotas at the home. Over a four-week period, the numbers of staff on duty each day varied. The staffing levels for the night duty also varied between four and two members of staff on duty for the whole of the home. There were times, especially during the night, when there were not enough staff on duty. We raised the staffing issues with Cumbria Fire and Rescue service. They told us that they had carried out a visit to the home in 2017 and had found no concerns.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing.

We looked at the recruitment records of one new member of staff. The registered manager had carried out the recruitment process in a safe manner. We saw that all the necessary checks, including identity and criminal record checks had been carried out. Information had been obtained about past employment including any training that prospective staff had undertaken.

There were processes and support in place to help the registered manager deal with any issues around staff discipline and performance.

Information about risks and safety had not been consistently kept up to date as people's needs changed. For example, falls risk assessments had not been reviewed and updated after someone had experienced a fall. Information about specific care and communication needs had not been included in hospital passports. We found the care records of one person stored in the records of another. There was conflicting information

recorded about the safe use of food thickeners, used to help prevent choking. This meant that people were sometimes placed at risk of receiving care and support that was not safe.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

We looked at how the service supported people with their medicines and at how medicines were stored. The provider had policies and procedures in place about the safe management and administration of medicines. Medicines had been safely and securely stored. There were appropriate arrangements in place for the safe keeping, recording and administration of controlled drugs. Special instructions, including side effects and contra indications of medicines were accessible to staff.

People kept their medicines safely in their own room if they wished. One person was managing some of their own medicines. A risk assessment had been carried out to help make sure they were able to do this independently and safely. There were two people at the home receiving their medicines in food or drink, mainly to aid swallowing. Where possible medicines had been obtained in liquid form but some had to be crushed and given with food. Although the GP had approved this method of administration, the pharmacist had not been consulted about this practice. Crushing or giving medicines with certain foods can reduce their effectiveness. However, the supervisor contacted the pharmacist as soon as we had brought this to their attention.

There were instructions for the use of 'when required' medicines such as pain killers although these were not always clearly documented in people's care records. This meant that staff were not fully familiar with the signs people showed when they needed their 'when required' medicines, especially where people had limited verbal communication skills. People kept their own topical ointments and creams in their rooms. This helped to make sure that staff administered them at the right time, for example after bathing. We found gaps in the records of creams and ointments. This meant that either the records had not been completed accurately or the creams had not been applied as the doctor had intended. We spoke to the supervisor about this matter.

Although there were systems and checks in place to help the registered manager and senior staff ensure medicines were managed and administered safely, they were not always effective.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

The service had policies and procedures in place about keeping people safe and protecting them from the risks of harm or abuse. Staff told us, and their training records confirmed, that they had received training to help them understand abuse and the actions they should take if they had any concerns. The staff told us that they would not hesitate to report any concerns about the behaviours and practices of colleagues or the registered manager. One member of staff told us, "If I saw anything I thought was abusive I would go to the senior or the manager straight away."

The people we spoke with during the inspection all said that they felt safe at the home. They did not raise any concerns with us about their safety. One relative told us; "The staff are very good. I am happy that my relative is safe here. I was dreading them coming into a home, but it has not been as I expected." Visitors and relatives told us that they were kept up to date with significant information when necessary.

The health and social care professionals we contacted told us that the home acted appropriately when

raising any safeguarding alerts and kept people safe. One health and social care professional told us; "I have found that the service reports accordingly if they have concerns which may be of a safeguarding nature."

When we visited the home, it was clean and there were no unpleasant odours. The housekeepers were clear about their roles and duties. They told us that there were usually two of them on duty but at times of sickness or holidays there would be only one housekeeper. They said, "We have a good team here and if needed the care staff help out too."

Staff used good infection control practices. Personal protection, such as gloves and aprons, were available throughout the home and used when necessary. The laundry was clean, tidy and well organised. The layout of the laundry was not ideal for keeping clean and dirty laundry separate but there was a system in place to help reduce the risks of cross infection.

Safety checks had been carried out appropriately. Equipment, such as hoists and other mobility aids were maintained in good and safe working order. Regular checks of fire, water and gas safety had also been carried out. However, there were gaps in the records of daily safety checks of equipment such as bed rails and specialist mattresses. Some of the communal rooms at the home were not in use. They had been used as storage rooms for equipment such as wheelchairs, raised toilet seats and handling equipment. These areas posed a risk to the safety of people using the service because they had not been locked to prevent unauthorised access. We told the registered manager about these concerns so that action could be taken quickly.

Emergency plans were in place and people living at the home had personal emergency evacuation plans in place. The plans were designed to help ensure the least disruption to services and to people using the service in the event of a major incident. There were systems in place to help monitor and manage incidents and accidents. The registered manager had started to review the incidences of falls and accidents to try to identify trends and take actions to reduce the risks of incidents re-occurring.

Requires Improvement

# Is the service effective?

## Our findings

We looked at how people were supported with eating and drinking. A specialist advisor assisted us with the review of nutrition at Petteril House.

Before our inspection of the service, the provider had told us of an incident relating to poor nutritional monitoring and management. We asked the provider to investigate and review their practices with regards to nutritional support. The provider carried out the review in June 2018 and told us what actions they would take to make improvements. We found that the provider had not taken the actions as they described.

Nutritional risk assessments had not been completed or had not been kept up to date as people's needs changed. People identified as being at risk of poor nutrition had not been monitored as frequently as they should have been. Staff had not used the malnutrition risk assessment tool effectively. Fluid intake records were poorly completed or people had not been offered enough to drink. Staff told us they had verbal handovers when they came on shift. There was nothing documented to support that staff were told about monitoring and encouraging people to take sufficient fluids. One person we spoke with told us that they were offered drinks at various times throughout the day but that they did not like to ask for extras. A member of staff overheard our conversation and brought the person a jug of iced water and a glass so that they could help themselves.

It was not always clear whether people at risk of poor nutrition had been reviewed by the doctor, dietitian or speech and language therapist (SaLT). Information and advice had not always been accurately recorded in their care records following a visit from the dietitian. Swallowing assessments and risk assessments had been stored incorrectly in other people's records, raising the risk of people receiving unsafe support with their eating and drinking needs. Recent changes to the use of food thickeners had not been consistently or accurately recorded in people's care records. Some of the fluid charts referred to 'stage 2' thickness prompting staff to use two scoops of thickener per 200mls of fluid when the SaLT recommendations were for seven scoops of thickener per 200mls of fluid. Giving people incorrectly thickened fluids raises the risks of choking and aspiration.

One of the people we spoke with said, "The menus are not great here. I have had to send meals back because the meat has been too tough to cut. There have been times when they (staff) have run out of the meal I chose, although they did offer me an alternative."

On both days we were at the home, we saw the service of the lunchtime meal. On the first day people were initially offered two options for lunch and portion sizes were adapted according to people's preferences. However, we later heard staff speaking about running out of one of the meal options. People were encouraged to eat independently if possible and they sat in small groups chatting with each other during the meal. Juices were topped up and tea was given out. There was no rush and one person was happily eating their salad and finger food at the table at 2pm. Assistance with eating and drinking was provided in a very dignified manner, at the persons pace, with cheerful encouragement and chatter about the day. When people had finished their meal, they were offered more or given a choice of desserts.

On the second day of our visit, we observed the serving of lunch in the dementia care unit. People were given support and encouragement to eat and drink when needed. There were options for lunch, but these were presented in a way that did not encourage people to make a choice. The lunch was of poor quality and portion size, although people were offered bread and butter to accompany their meal. One person sent their meal back and were given the option of a sandwich, which they accepted. The home operated 'protected mealtimes'. However, we observed that this was not always adhered to as one person was disturbed by a visitor during their lunch. This caused them to become mildly distressed.

We spoke with the chef and reviewed the four-weekly menus at the home. The chef was aware of people's special dietary needs, including those who needed a textured or fortified diet. There was a supply of frozen and fresh vegetables as well as a good supply of butter, cream and full fat milk for food fortification. There were some days where meal options lacked sufficient protein and portions of fruit and vegetables. The government guideline, 'The Eat Well Guide' advises five portions of fruit and vegetables per day. Our observations and review of records demonstrated that this guidance was not always followed

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 – Meeting nutritional and hydration needs.

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 that 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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff at the home had received basic awareness training regarding the MCA and senior staff had received additional training about DoLS.

The registered manager had made applications to deprive six people of their liberty. However, there was no evidence to support that initial assessments had taken place to establish whether people had the mental capacity to make their own decisions. The operations manager confirmed that capacity assessments had not taken place and that the service had been advised to complete the DoLS application forms. This process was incorrect and did not follow the principles of the MCA or the provider's own policies and procedures. If it is established that a person has capacity a DoLS application is not required.

The sample of care records we reviewed did not contain capacity assessments or best interest assessments, although care plans and risk assessments recorded that support was provided in people's 'best interests'. One person had capacity to make decisions. Their care plans and risk assessments stated that support was provided in their 'best interests', which was incorrect. Another person had bed rails fitted to their bed. There was no mental capacity assessment to show whether the person was able to choose to have this piece of restrictive equipment used on their bed. The service had completed a risk assessment about the use of bed rails but there was no rationale to demonstrate that they were the most appropriate and least restrictive method of keeping this person safe.

There was one person at the home subject to DoLS. Staff supporting this person did not know where the DoLS authorisation was kept or what information was contained in that document. Information relating to care and support delivered in the person's best interests should be clearly recorded in care plans and cascaded to staff supporting that person. Additionally, the provider is required to notify CQC when DoLS authorisations are granted. However, they had failed to do so.

The service did not fully understand or put into practice the requirements about mental capacity and consent.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 - Need for consent.

We contacted health and social care professionals, who were involved with the home, for their views on the service. Three people responded and provided both positive comments and commented on areas where the service could improve. One health and social care professional said, "The senior staff have asked for my assistance, advice and input if they are unsure and need further support or advice. My view is that Petteril House is seeking to improve on providing a consistent level of care from its staff." Another commented, "The staff there have been very supportive and understanding to one particular person's needs. They coped with challenging behaviours in personal care and have identified changes to behaviours and acted quickly to have them physically checked." A third person told us that they had visited the home to carry out a review of a person who lived at the home. They found that part of their care plan was missing and that staff could not provide an explanation for this. This would have held up the review process.

People told us they were supported to access their doctor if they needed them. One person told us, "If I am not well they (staff) will get the doctor for me." We also read in the communication diary and personal records that people had access to other health and social care staff such as community nurses, chiropodists, opticians and their social worker. Advice and recommendations following their visits were not always clearly recorded in people's care records. We saw from the minutes of a recent supervisors meeting that the registered manager had identified this as an issue and provided the supervisors with instructions to help make improvements.

The staff we spoke with told us about the training and support they received to help them carry out their roles effectively. They told us they received supervision "every couple of months" to discuss their work load and training needs. The staff training records we looked at showed that staff had completed induction training and further, nationally recognised training in health and social care. The recording system identified the training completed, when it was due to be refreshed and planned dates for training courses. The registered manager checked these records each month to help ensure they were up to date.

We observed staff supporting some of the people who used the service. Staff demonstrated good practice skills, particularly when supporting people with their mobility and infection control practices. One of the people we spoke to commented on the skills of the staff that supported them. They said; "The ability of the staff fluctuates. They are all well-meaning but some of the newer staff, learners, get a bit mixed up sometimes."

Petteril House is an older designed property with accommodation over two floors. There were plans to move to new premises in early 2019. Information about the new home was available to people who used the service and their relatives and friends. The format of this may not have met the communication needs of some people.

Appropriate signage around the home helped people orientate themselves to their own rooms and to communal rooms. In the dementia care unit 'memory boxes' had been placed outside people's bedrooms. The boxes contained personal mementos and photographs to help people recognise that this was their own room. Everyone at the home had been able to personalise their own space with ornaments, pictures, televisions and radios to help make their room more 'homely'. The bathroom and toilets at the home were fitted with equipment to help people access the facilities independently or with support in the case of bathing and showering. However, these areas were very clinical rather than 'warm' and 'homely' in appearance.

Requires Improvement

# Is the service caring?

## Our findings

Due to the concerns identified during the inspection, we could not be assured that people received a high quality compassionate service. We have taken this issue into account when rating this key question.

People told us that they were happy with the way in which staff treated them. One person told us, "I have been here a number of years now. I am well looked after and I like being here. Staff help me to have a bath and they are kind and thoughtful." Another person said, "I am looked after nicely. Staff pop their heads in and have a chat with me, ask if I want anything." One of the people who lived in the dementia unit told us, "I am comfortable here. The girls (staff) help me if I need it. I am quite alright here thank-you."

A relative said, "I can't fault the service or the staff. They (staff) are really good and look after my relative really well." Although most of the comments we received were positive about the staff and the service, one person said there were sometimes issues with communication. Messages did not seem to be passed on from staff to the registered manager. They also thought that staff were not always attentive as they could be towards their relative.

We saw staff treated people with kindness and respect. Staff were attentive to people's needs and provided explanations prior to helping them. When people needed help with their personal care needs, this was carried out discreetly and in the privacy of their own room or bathroom.

Most people living in the dementia care unit were unable to speak with us. We saw that people appeared well groomed and cared for. There was chatter and laughter between people and the staff. People in this part of the home appeared relaxed and happy in the company of each other and the staff supporting them. The atmosphere was calm and staff had time to spend with the people they supported. One person was sleeping when it was time for lunch, but staff woke the person gently and explained it was lunchtime. The person responded positively with a smile.

People had the opportunity to have their say about the home and things that affected their day to day lives at Petteril House. The registered manager held meetings on a regular basis, although these meetings were aimed at people with good verbal communication skills. We saw that some suggestions had been taken on board by the management and addressed, although there remained areas where improvements still needed to be made.

Information about other services was available at the home if people wished to access them. For example, advice about specific conditions, care, support and advocacy services. This information was not easily available in alternative formats. The provider said that some information could be produced in alternative formats to help meet people's communication needs. Some people living at the home would not be aware of this or be able to make a request.

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

Requires Improvement

# Is the service responsive?

## Our findings

People who lived at Petteril House had care and support plans in place. In the sample of care records that we looked at the person or their relative, had been involved in the development of the plan. The care and support plans had not always been kept up to date. Some of the information recorded was confusing, particularly about whether people had capacity to make decisions about their care. The plans focused mainly on care tasks. Little consideration was given to the social and leisure aspects of people's lifestyles. One of the care records we looked at had a very good example of a 'Life Story' book. This provided staff with information about the person's life history, interests and photographs of their family. 'Life Story' books are good practice and help providers to develop interesting and relevant leisure and social activities for people using services.

During our inspection visits, we did not see much to support that people were provided with, or encouraged to participate in leisure and social activities. On one day we saw staff engaging with a group of people and playing a memory game, which everyone seemed to enjoy. We asked people living at Petteril House about the social aspect of their lives. One person said, "There is not much to do really." Another person told us that they preferred to stay in their room. They said, "There are sometimes things going on down the corridor. I do try to go sometimes but I am limited at what I can do."

We did not see any activities taking place in the dementia care unit. One or two people spent time sleeping in their chairs. One of the health and social care professionals we contacted told us that they had offered to provide bespoke training. Staff on that unit had requested training regarding life story work and engagement specifically for the dementia care unit. Although the training was planned no one attended. They also said that they had later been contacted by staff asking for advice about being more creative on the unit and introducing more activities. The NICE quality standard on dementia care states that service providers should have protocols in place to ensure that personalised care plans identify a named care coordinator and address the individual needs of people living with dementia, taking into account, diversity, life stories and individual preferences, including social and leisure interests.

The registered manager said staff organised activities when they had time, dependent on the staffing levels. They told us that activities usually consisted of bingo, quizzes and chair exercises. Entertainers such as singers and musicians came into the home on occasion and some people went out with their families. The registered manager also said that if staffing levels were sufficient, staff took people out to a local café or garden centre on the community bus. The home was not visited by any religious groups, vicars or priests.

The minutes of the last two 'residents' meetings' recorded that people had discussed the lack of activities at the home. One person had said that they were sometimes bored and would fall asleep.

We recommend that the service seek advice and guidance from a reputable source about effectively supporting people to follow their interests, encouraging them to participate in social activities relevant to their interests and maintain personal or community relationships.

The service had started to consider the Accessible Information Standard to identify, record, flag, share and meet the information and communication needs of people with a disability or sensory loss. A policy and procedure had been developed alongside documents specifically designed for this purpose. However, we did not see any evidence to support that people's communication needs were being met.

There was a robust complaints process in place. There was clear guidance to help people raise concerns about the service if they were not happy. The registered manager told us about the complaints that had recently been received. We looked at these during our inspection. The complaints and actions taken to resolve the complaints had been documented, together with the outcomes of any investigations.

No one was receiving end of life care at the time of the inspection. Staff had received training to help them support people during this phase of their life. Protocols were in place so that the home could work closely with community nursing teams. Arrangements were in place for the use of any anticipatory drugs should they be needed. Where people had made the decision not to be resuscitated in the event of cardiac or respiratory arrest, this had been discussed with their doctor and recorded in the care files.

Requires Improvement

# Is the service well-led?

## Our findings

There was a registered manager at the service. The registered manager was at the home and assisted us with the inspection process. Following the inspection visit, we asked the registered manager to send us some information. The registered manager provided this in a timely manner.

Policies and procedures were in place with regards to quality monitoring and governance. Registered managers and supervisors were responsible for self-auditing their areas of responsibility. There was oversight from the operations managers and the provider's internal quality assurance and governance team checked the frequency and quality of the audits at least annually.

There was a system in place for recording and monitoring the progress of DoLS applications that had been made. The process for making the applications had not been correctly followed. Where applications had been granted, the registered manager had not notified us of this as required.

This was a breach of Regulation 18 of the Registration Regulations 2009 – Notifications of other incidents.

Before our inspection we had asked the registered manager to investigate an incident that had resulted in a person suffering harm. We asked them to update us with their findings and of any actions taken. Their investigation report identified where the service had failed and what was going to be put in place to address the shortfalls. The actions had not been fully implemented.

Audits (checks) of medicines and records had been carried out. The checks had failed to identify the medicines discrepancies and concerns we had found during our inspection. Important information about people's care and support needs was either missing from their records or was out of date. Confusing information was recorded about people's nutritional support and mental capacity. The registered manager's checks had failed to identify these concerns.

The operations manager visited the service regularly. Their visits included reviews of files, records, speaking to staff and people living at the home. Additionally, they looked at the occupancy levels and staffing levels. The registered manager was provided with a written report following their auditing visits. We asked the operations manager if action plans were developed to help make sure any shortfalls they had identified were adequately addressed. They told us that action plans were not used but the audit report would be used as a checklist the following month. The operations manager's audits had also failed to identify and address the issues found during our inspection of the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

The registered manager told us that staff supervision took place and that staff were provided with opportunities to formally discuss their practice, concerns and development. Staff meetings regularly took place. We looked at some of the meeting records. The meetings included feedback from the registered

manager following audits and checks that had been carried out. The feedback directed staff to areas where improvements needed to be made as well as what had gone well at the home.

People who lived at the home were given opportunities to comment on the operation and quality of the service. Meetings were held and there had recently been a quality satisfaction survey carried out. The report of the findings had not been produced at the time of our inspection.

The service had links with the community mental health team, community nursing service and with the local social work team. This helped to make sure people could access health and social care services when needed. There were limited links with the local community with regards to social and leisure activities. Links were limited to occasional visits to cafes or the garden centre when staff had the time.

We looked at how the service managed records, particularly those relating to people who lived and worked at the service. Records containing personal and sensitive information had been stored safely and securely.

The registered manager told us that they carried out monthly reviews of accidents, incidents, complaints and safeguarding to help identify trends and learning points for improvements. They showed us the work they had started with regards to falls monitoring and management. We found that information about falls had been recorded. It had not yet been analysed to help identify areas of improvement to reduce any further risks of harm or injury to people at the home.

Infection control and prevention audits had been carried out. Action plans were produced and further audits completed to check whether any shortfalls had been adequately addressed.

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<br><br>The service had not submitted notifications as required. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The service did not fully understand or put into practice the lawful requirements about mental capacity and consent.<br>Regulation 11 (1)(3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The service did not adequately meet the nutritional and hydration needs of people living at the home.<br>Regulation 14 (1)(2)(4)(a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The systems to monitor compliance and improve the quality and safety at the service were not effective.<br>Regulation 17 (1)(2) |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider did not deploy sufficient numbers of staff to meet the needs of people using this service.
Regulation 18 (1)