Innowood Limited

Kingswood House Nursing Home

Inspection report

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Date of inspection visit: 24 and 25 August 2015
Date of publication: 16/11/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection was carried out on 24 and 25 August 2015 by two inspectors, a specialist clinical adviser and an expert by experience. It was an unannounced inspection. The service provides personal, nursing care and accommodation for a maximum of 22 people.

The staff provided nursing and personal care for people with enduring mental health conditions, some of whom had a history of substance or alcohol misuse and a forensic background. Some people also had complex physical health conditions and behaviours which may challenge. Many people stayed at the service on a long term basis and may previously have experienced homelessness. The provider told us they aimed to support people to move to more independent services if their health needs allowed this, to enable them to live without full time support and nursing care.

Summary of findings

There was an acting manager in post who was acting up from a previous deputy manager role. The previous registered manager had recently resigned from their role. The service was in the process of recruiting a new full time manager who was due to take up the post, dependent on satisfactory recruitment checks. At the time of our inspection there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff had attended training in how to protect people from abuse and harm. However staff were not confident in describing how they would recognise potential signs of abuse and what processes they needed to follow to keep people safe. They said they would benefit from additional training in this area.

Staff did not have the necessary training to meet the individual needs of people at the service. One to one supervision sessions for staff were carried out, however staff had not received spot checks to observe their care practice, to support them to increase their performance and competence. Annual appraisals had not taken place, however they were scheduled to take place in 2015.

Staff were not able to describe the basic principles of the Mental Capacity Act (2005) (MCA) to ensure they supported people legally in line with their consent. Staff said they needed training to better understand the requirements of this legislation. The provider had scheduled staff training in MCA and DoLS on the 15 September 2015.

There was insufficient staff to meet people's needs. There was not enough management hours allocated to support the effective operational running of the service. Whilst the provider had measures in place to recruit a new manager, deputy manager and additional nursing staff, this staffing arrangement was not in place at the time of our inspection.

A lack of adequate training in safeguarding adults; a lack of adequate training and staff support to meet people's individual needs and a lack of sufficient staffing levels to meet people's needs are breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an improvement plan for the decoration and maintenance of the premises, however repairs we identified were not recorded on this plan. The acting manager said that it was difficult to change anything in the home as people often resisted change due to their health conditions. However, this should not prevent action being taken to make sure people remained safe.

Failure to ensure the environment is properly maintained to keep people safe is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a system for monitoring the cleanliness or maintaining effective infection control standards at the home. Where people had blood borne viruses or infectious diseases, there was no protocols in place to reduce the risk of infection to them and others. The provider had not adequately assessed infection control risks including those that are health care associated.

Peoples care plans were not consistently reviewed to reflect any changes in their care and treatment needs. Where the responsibility for people's care and treatment was shared with other people to include health care professionals, reviews of care had not always taken place with their involvement, in a timely and formalised way. Care reviews did not take into account preventative measures to ensure the health, safety and welfare of people.

The failure to provide safe care and treatment; to protect people from harm by ensuring the premises are safe; to assess the risks of infections, protect people from these risks and provide a clean and hygienic environment which is properly maintained are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's individual risk assessments included measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm.

Summary of findings

Although risk assessments were in place they were not always up-to-date. People could not be assured that risks would be managed appropriately due to a lack updated records.

Audits were completed, however they did not adequately identify how the service could improve. The provider had not always identified all shortfalls or acted on the results of audits to make necessary changes to improve the quality of the service and care for people.

The service sought people's feedback, comments and suggestions. However, the provider had not explored accessible means of obtaining people's feedback. The provider had not analysed the results of any feedback given by people and acted upon this to improve the service.

Accidents and incidents were recorded, however they had not been monitored or analysed to identify how the risks of re-occurrence could be reduced to keep people safe.

Failure to adequately assess, monitor and improve the quality of the service, to include people's views of the service, and the failure to ensure risk assessments records are up-to-date are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not know each person well or understand how to meet their support needs. Each person's needs and personal preferences had been assessed before they moved into the service, however, staff did not always have accurate knowledge to provide person centred, consistent care.

People's care plans did not take into account or monitor progress with people's longer term goals and objectives. Where people had expressed a preference to move on from the service, this had not been assessed to support those people to work towards meeting their goals where possible.

There were insufficient activities for people to engage in at the service. The acting manager and activities co-ordinator tried to involve people in the planning of activities. They said that it was difficult to engage people in activities. Some people were able to go out independently.

Failure to provide person centred care and treatment to meet people's needs, to include activities and failure to provide care or treatment designed with a view to achieving people's preferences are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not notified the Care Quality Commission of all significant events that affected people or the service. We brought this to the attention of the provider and they implemented training sessions for the acting manager to update their knowledge in this area. It was too soon to evidence whether there was an improvement in this area.

Failure to notify CQC of significant events at the service is a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Most staff treated people with kindness and respect. However, we observed one incident where a staff member spoke with someone in a way which was not compassionate or caring and did not promote their dignity. The acting manager was concerned to hear about this and said they would act swiftly to address this. Not everyone was satisfied about how their care and treatment was delivered.

We have made a recommendation about training for staff in providing care and support to people with dignity and compassion.

Information about how to access advocacy services was not provided in a clear and accessible way to all people. There was no information on activities available to people. Menus and satisfaction surveys were provided for people in a suitable format.

We have made a recommendation that the provider explores different ways of giving people information about services available to them in accessible formats and supports people to access these services.

Information leaflets were available to inform people about the complaints procedure. However these were not always provided in an accessible format. People were not always aware of how to make a complaint. No complaint had been received in the last 12 months before this inspection.

We have made a recommendation about giving people information about how to make a complaint in accessible formats and supporting people to make a complaint when required.

Summary of findings

Not everyone had their cultural and spiritual needs met.

We have made a recommendation that the provider reviews and supports people to meet their diverse care, cultural and spiritual needs.

There were safe recruitment procedures in place which included the checking of references.

Accidents and incidents were recorded and although there was no system to analyse these to look for patterns or trends individually, control measures were put in place to reduce risks to people. All fire protection equipment was serviced and maintained.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people required a DoLS the acting manager had completed DoLS applications appropriately. They understood when an application should be made and how to submit one.

The service provided meals that were in sufficient quantity, well balanced and met people's needs and choices. Staff knew about and provided for people's dietary preferences and restrictions.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not adequately trained to protect people from abuse and harm as they may not recognise potential types or signs of abuse.

The environment was not clean or well maintained. Control measures were not in place to reduce the risk of infection or to ensure the environment was safe.

There was insufficient management staff to ensure the safe operational running of the service to meet people's needs.

Risk assessments were in place, however they were not up-to-date in all cases. People could not be assured that individual risks would be managed appropriately.

Is the service effective?

Requires improvement

The service was not effective.

Staff were not adequately trained and did not have the required competence to meet people's individual care and treatment needs.

The acting manager understood when an application for DoLS should be made and how to submit one. However, staff were not adequately trained in the principles of the MCA (2005) and were not knowledgeable about the requirements of the legislation.

Care and treatment was not always planned or delivered to meet people's individual needs. Staff did not always have the required knowledge to meet people's individual care and treatment needs.

People's cultural and spiritual needs were not met in all cases.

Is the service caring?

Requires improvement

The service was not consistently caring.

Most staff treated people with kindness, compassion and respect. People's privacy and dignity was respected by staff. However we observed one incident where a staff member spoke disrespectfully to someone. The acting manager told us they would address this with the member of staff.

The provider had not considered accessible ways to inform people about services available to them, to include advocacy.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

Summary of findings

Is the service responsive?

Inadequate

The service was not responsive.

Care plans and risk assessments were not always reviewed regularly and updated when people's needs changed. People's care had not been designed or delivered to meet people's preferences and ensure their individual needs were met.

Where the responsibility for people's care and treatment was shared with other people to include health care professionals, reviews of care had not always taken place with their involvement, in a timely and formalised way.

There were inadequate activities based on people's needs and wishes available at the service.

The provider had not considered accessible ways of consulting all people to obtain their feedback about the service. Where people's feedback had been obtained, it was not recorded what action had been taken to address comments made.

Is the service well-led?

Requires improvement

The service was not well led.

The quality assurance system in place did not effectively identify all service shortfalls. The action plans did not record when actions should be completed, to ensure service improvements were made.

The provider had not notified us of significant events at the service in line with their regulatory and legal obligations.

Staff were not clear on their roles and responsibilities and did not have a clear understanding of the provider's philosophy of care to ensure people were provided with continuity of care.

Kingswood House Nursing Home

Detailed findings

Background to this inspection

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

This inspection was carried out on 24 and 25 August 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience. The specialist advisor had professional experience of mental health and substance misuse services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The acting manager had not received a Provider Information Return (PIR) request at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during the inspection. Before our inspection we looked at records that were sent to us by the provider or the local authority to inform us of significant changes and event. This service had not been inspected since it registered under new provider ownership in October 2013.

We looked at records which included those related to people's care, staff management, staff recruitment and quality of the service. We looked at eight people's assessments of needs and care plans. We made observations to check that their care and treatment was delivered consistently with these records. We looked at the activities programme and the satisfaction surveys that had been carried out.

We spoke with thirteen people to gather feedback about their experience of the service. We spoke with the acting manager, the operations manager, a nurse and three members of care staff. We consulted a local authority quality monitoring officer and a practice nurse to obtain their feedback about the service.

Inadequate

Is the service safe?

Our findings

Some people told us they felt safe living at the home. However, one person said, "It can be violent in here sometimes." Not all staff felt confident about what strategies they should use to keep people safe, when people presented with behaviours that may challenge.

Policies and procedures were in place to inform staff how to deal with any allegations of abuse. Records showed staff had completed training in safeguarding adults. However, staff were not confident in describing how they would recognise potential signs of abuse and what processes they needed to follow to keep people safe. Staff were able to describe their duty to report concerns to the acting manager and the local authority safeguarding team. Contact details for the local authority safeguarding team were available to staff if they needed to report a concern. Staff said they would benefit from refresher training in safeguarding to increase their confidence levels in identifying and acting on incidents of potential abuse. A lack of adequate staff understanding of safeguarding policies and procedures had been identified as part of a local authority audit completed in April 2015. This has not been satisfactorily addressed by the provider.

There was a whistleblowing policy in place. Not all staff were aware of this policy or knew how to report any concerns they had about potentially poor staff care practices.

A lack of adequate training in safeguarding adults had the potential to leave people at risk of abuse or harm and staff unable to recognise this and therefore potentially not act appropriately. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A significant safeguarding incident occurred in June 2015, where a person died at the service due to choking on some food. They had required a specific eating regime to reduce the risk of choking and needed to be supervised at all times during mealtimes which had not always been acted on. An investigation took place which involved the provider, local authority, the person's family and CQC. The investigation reviewed care practices to ensure lessons were learned to reduce future risks to people. The acting manager talked to staff in team meetings about this. Staff said, "After this incident we were offered support as it upset everyone. We talked about what we could do differently in the future." Staff talked to us about new measures in place. One supervisor was now in the dining room at all mealtimes and a member of staff would sit with people who were at risk of choking. Records were kept of what people had eaten after every meal. We observed these measures were in place at lunchtime.

Staff worked with the local authority and implemented their recommendations. People at risk of choking had an assessment completed by the local Speech and Language Therapy Team (SALT) and new care plans were completed for them. SALT guidelines were in people care plans where needed and in the kitchen for the chef to follow. Staff received refresher training in understanding people's SALT needs. Therefore lessons had been learnt and staff were supporting people in a way that would reduce the risk of this incident reoccurring.

The premises were not suitable for the people who lived there, although people said they liked the home as it was. Some areas of the home were not in a good state of repair. One person who used a walking frame to aid their mobility showed us their room. The threshold strip between the hall and the room floors was loose with a raised nail in one side. This person said, "I have told the staff twice and I think it is dangerous." Nothing had been done to make this safe. They also pointed out there was no bulb in their room light and this had been out of order for more than one week. They said the staff were aware of this. Neither of these items for repair had been recorded by the staff in the repairs and maintenance book. The bathroom on the top floor had cracked tiles which posed a risk of people hurting themselves whilst using the room barefoot. We saw that beside the lift on the ground floor there was a broken plastic storage box containing a vacuum and other equipment. This had jagged edges and as one person used a wheelchair there was little room to access the lift without coming into close contact with the sharp edges.

The staff and the provider had not recognised these hazards or taken action to minimise the risks they posed to people's safety. There was no system for assessing that the premises were safe and that any repairs were carried out in a timely way. When repairs had been reported there was no way of monitoring if and when they had been completed. An audit completed in May 2015 had identified that a number of doors did not meet fire safety standards. The

acting manager said they had referred this information to the provider, however the doors had not been replaced and there was no date recorded as to when replacement doors would be fitted.

We discussed these concerns with the operations manager and the acting manager. They understood there were changes to the premises that were needed but they had not been aware of all of the areas of safety we raised with them. The provider had an improvement plan for the decoration and maintenance of the premises, however these repairs were not identified on this plan. They did say that it was difficult to change anything in the home as people living there resisted change due to their health conditions. One member of staff said, "For me the home needs lots of TLC (tender loving care) but it requires lots of work engaging the residents, as any change can be disruptive." However, this should not prevent action being taken to make sure people remained safe.

The failure to protect people from harm by ensuring the premises are safe is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they thought the home was clean. One person said, "The place is always clean and tidy." However other people were not satisfied with hygiene levels at the home. One person said, "It's very dirty and very unclean here."

Out of the five bathrooms and toilets we saw at 9.30 am, only one had supplies of paper towels, soap and toilet paper. We asked the cleaner whether they were responsible for supplying these areas. They were unclear whether this was their role. We then asked the acting manager whether it was normal, or if there was a reason not to have supplies available for people to use. They said that it was not and they would see supplies were put in these toilets. One person who had just used a toilet told us there was rarely any toilet paper. They said, "I don't know if we are entitled to have any but I took some from the staff." There were hand washing signs in each toilet and bathroom but people and staff were unable to follow these infection control instructions as they did not have the equipment they needed. By 11.35am supplies had still not been put into these areas. We told the operations manager about this and they said, "I am very concerned to hear this and will act on this."

The bathrooms and toilets were not all clean despite a cleaner working at the home during the inspection. We saw an unclean toilet brush sitting in unclean fluids without any lid to prevent spillage. There were marks around toilets and some sinks. The cracked tiles and loose flooring in bathrooms and toilets made effective cleaning difficult. The cleaner and other staff were unable to tell us who took the lead on infection control. The nurse on duty said, "No one is in charge of infection control and no one has told me anything." The acting manager told us one of the nurses was designated infection control lead. This nurse had left a message for the acting manager dated the 2 April 2015. This reported what needed to be done to make the downstairs bathroom suitable to meet infection control standards. This work had not been carried out. The acting manager said, "We need a checklist as there is no way of checking the cleaning has been done to the right standard." The provider did not have a system for monitoring the cleanliness or infection control measures. Although there had not been outbreaks of infectious diseases the risks for people were increased due to the lack of supplies and inadequate cleanliness.

The nurse on duty told us staff always used personal protective equipment such as aprons and gloves and we saw this being used when people were supported with their personal care. Staff said they had been trained in how to use this equipment. However, we found information in daily records that people had blood borne viruses (BBV). The acting manager was not aware of this. They could not advise us of infection control measures in place to reduce the potential risk of infection and were not sure whether staff had received the required immunisations to carry out their work safely. Where people had a BBV, there was no information in their care plan to effectively manage their needs and reduce the risk of infection to them and others. The provider had not assessed the risk of infection, including infections that are health care associated.

The failure to assess the risks of infections, protect people from these risks, provide a clean and hygienic environment which is properly maintained is a breach of Regulation 12 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place which identified people's individual needs. For example, where someone had a need for a hoist to transfer or assistance with their mobility, the appropriate risk assessments had been undertaken on

admission. People's moving and handling needs were clearly recorded where people were at risk of falls. Guidance and daily instructions were clearly recorded for staff to follow. Mental health team assessments were also in place, for example one person was assessed to be safe to go out for the day unaccompanied. However five care plans and associated risk assessments were two to three months out of date and required review. People could not be assured that any risks would be managed appropriately due to a lack of updated records.

Failure to ensure risk assessments records are up-to-date is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff told us that there were sufficient numbers of staff to meet people's needs. One member of staff said, "I think overall there are enough staff. However I think we could benefit from an extra member of staff in the mornings to help people to get up. Also I would like to have more time to have one to one's with people, so that this feels less rushed." We observed the staff were not rushed, carried out their tasks in a calm manner and were able to spend time talking with people. Agency staff were used to cover staff sickness or other absences. The acting manager completed staff rotas to ensure that staff were available for each shift. There was an on-call rota so that staff could call a duty manager out of hours to discuss any issues arising. Staff were available when people needed to attend medical appointments or other events.

On the first day of our inspection the Registered Nurse (RN) was also the acting manager. They had competing demands on their time to include management of the home, ensuring staff supervision, at the same time as providing nursing care to people. The acting manager only had twelve hours per week within which to manage the operational running of the home outside of their RN role. We raised concerns about this staffing issue with the provider through email correspondence on 31 July 2015, after concerns were reported to us by the local authority. We discussed these concerns again at a meeting we attended with the provider on 19 August 2015. Whilst there was a clear plan to recruit a new manager, deputy manager and additional nursing staff to the service, this staffing arrangement was not in place at the time of our inspection.

A lack of sufficient staffing levels to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked staff files to ensure safe recruitment procedures were followed. We found that suitable checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the home until it had been established that they were suitable to work with people. Staff members had provided proof of identity, residence and of the right to work in the UK prior to starting work at the service. References had been taken up before staff were appointed. Staff were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured that staff were of good character and fit to carry out their duties.

Records of accidents and incidents were kept at the service. When incidents occurred staff completed incident reports and informed the acting manager and other relevant persons. Staff discussed accidents and incidents in daily handover meetings. One incident recorded where someone had a fall in their room. Staff checked for potential hazards in the person's room, referred them to their GP for a review of their medicines, monitored their blood pressure and spoke with the person to assess any adverse physical symptoms they may be experiencing. These risk management measures were taken to reduce the risk of incidents re-occurring.

Staff were trained in first aid and fire safety practices. The records confirmed that staff had received fire safety training. The acting manager said that fire procedures were a 'work in progress'. One fire evacuation drill had been completed on 16 June 2015 and an action plan had been implemented which identified safe zones for people to assemble at and which people needed to be prioritised based on their physical and mental health needs.

People had individual Personal Emergency Evacuation Plans (PEEP) in place that took account of their specific needs in case of emergencies or evacuation. The PEEPs identified people's individual independence levels and provided staff with guidance about how to support people to safely evacuate the premises. A stair climber had recently been fitted as an additional measure to ensure people could access downstairs in the event the lift broke down, or if people needed to evacuate the premises in the event of a fire. Risk assessments had been carried out as some people smoked in a designated smoking room and occasionally in their bedrooms.

Inadequate

Is the service safe?

The equipment people required including wheelchairs, bath hoists and adapted baths as well as electrical and fire equipment had been tested to make sure it remained safe. Staff had been trained and they knew how to use the equipment safely. The fire alarm was tested weekly and all fire protection equipment was maintained, regularly serviced and checked. There were clear signs throughout the premises to indicate fire exits and exits were fully accessible.

People were supported to take their medicines by staff trained in medicine administration. Staff had their competency assessed before supporting people with their medicines. Records showed that staff had completed medicines management training. We observed two members of staff completing a medicines round appropriately. This included checking for correct dosages, recording and signing when they gave people their medicines and locking the medicines away securely afterwards. All Medicine Administration Records (MAR) were accurate and had recorded that people had their medicines administered in line with their prescriptions. The MAR included people's photograph for identification. Individual methods to administer medicines to people were clearly indicated. Where people were independent with their medicines for example, applying prescribed creams, this was written in their care plan. The provider carried out audits to ensure people were provided with the correct medicines at all times. This system helped ensured that people received their medicines safely.

Requires improvement

Is the service effective?

Our findings

Some people said they were satisfied with the support they received from staff. One person said, "its okay being here" and "My needs are being met. My medication is helping me" and "This place is meeting my needs." Another person said they were happy and content and staff knew their care needs. They discussed how they liked the home and they stated they had 'demanded to come here' from their previous living accommodation. Other people were not sure whether their care and support needs were being met. People said, "Are my needs being met? I don't know" and "I don't know if I feel supported."

Staff had not received adequate training to support people with their individual needs. Staff had an induction and essential training included medicines management, fire safety, manual handling, health and safety, mental capacity and safeguarding. However staff told us they needed training in all areas as they were not confident in supporting people with their individual needs. Staff said, "I would like more training in everything really. Particularly around people's mental health and supporting people with challenging behaviour. I would like to know more about how to respond to people needs around their behaviour." One member of senior staff said, "The staff do the best they can with the knowledge they have."

We overheard an incident which showed that not all staff understood the approach they should take to support people consistently according to their needs. We heard one man start to raise their voice. A member of staff responded by saying,"Oy don't shout" in a loud and abrupt tone. The nurse on duty when asked about this advised this was not the normal way to respond to this person. Staff should use a quiet voice as otherwise the person's behaviour could escalate. We described this incident to the acting manager later who was concerned to hear this. They said staff should not speak to people like that. The acting manager said some staff had received mental health training, but from this incident the member of staff was not using their training to provide effective therapeutic care. The acting manager had written in the communication book they would provide training in behaviours that challenge and this was scheduled to take place.

Staff said they would benefit from having more practical training rather than reading training materials. One member of staff said, "I would also like more practical training in use of CPR." Cardiopulmonary resuscitation (CPR) is a first aid technique that can be used if someone is not breathing properly or if their heart has stopped. There was a training plan to ensure training remained up-to-date. However, staff competence and confidence levels had not been assessed to ensure staff were competent following any training, to meet the needs of people they supported. Staff had not completed specialist training to support people with their individual needs around mental health, substance misuse, diabetes and behaviours which may challenge. Staff were not satisfied with the training options available to them. The operations manager told us and we saw they had a training plan to include training in the specialist subjects required. However at the time of our inspection, staff did not have the necessary training to meet the needs of people at the service.

One to one supervision sessions for staff were regularly carried out in accordance with the home's supervision policy. However the provider had not carried out spot checks to observe staff care practice, to support staff to increase their performance and competence. Staff's performance and training needs were discussed at supervision. However, annual appraisals had not been completed. We discussed this with the acting manager who was aware of this shortfall and had scheduled formal appraisals in 2015 for all staff.

A lack of adequate training and staff support to meet people's individual needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). Concerns were identified about a lack of staff knowledge and training in DoLS at a safeguarding meeting which we attended in August 2015. This led to the service working closely with the local authority to improve practice in this area. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and DoLS with the acting manager. They had appropriately completed documentation when people's mental capacity had been assessed to determine whether they were able to make certain decisions. Such decisions included consenting to their care and treatment. When people did not have the relevant mental capacity, meetings had been held with people's legal representatives to make decisions on their behalf in their best interest. The acting manager had submitted appropriate applications to

Is the service effective?

the DoLS office to seek their authorisation when people were restricted of their liberty in their best interest. They followed the DoLS guidance about the submission of applications. Attention was paid to ensure the least restrictive options were considered, in line with the principles of the MCA (2005) and DoLS.

Staff said they were not confident in knowing how to support people who lacked capacity to make decisions. Staff could not describe the basic principles of the MCA (2005). One staff member said they had not had training in the MCA and other than reporting concerns about someone's mental capacity to their manager, they would not know what to do to best support the person. One staff member said, "If I was unsure if people had capacity to understand something, I would ask questions in different ways to see if they could understand me. I might show them things to help them understand what I meant. I might contact the person's social worker or GP for a mental capacity assessment." MCA (2005) training had been arranged for staff and was due to take place on 10 September 2015.

Updates concerning people's welfare were appropriately communicated between staff at handover meetings to support people's continuity of care. We attended a handover meeting and observed staff discussions taking place. For example, information about people's individual health, mental state, behaviour and appetite was shared by staff at each shift change. Reviews of people's health needs were discussed. For example, one person needed a review of their diabetes due to changes in their glucose levels and one person was due a review of their skin by a Tissue Viability Nurse. Whilst we were there staff responded to someone's emergency call bell and the emergency services had been called. Staff called the hospital later that day to see how the person was getting on. People had health care plans which detailed information about their general health. Records of visits to healthcare professionals such as G.P.'s, chiropodists, opticians and dentists were recorded in each person's care plan. People's care plans contained clear guidance for care staff to follow on how to support people with their individual health needs.

Despite these measures to try to maintain people's health we found people were not always effectively supported. The nurse said care plans were 'chaotic' and they were trying to work with staff to improve them. They said the care plans did not set out people's needs or guide the staff to provide effective care. The nurse and a member of staff were discussing one person's need for nursing care and to have their dressings changed. The nurse said they had put the dressings in the person's room but they had been moved. The nurse then said it was unclear whether staff had been doing the dressings. The person's care plan stated they required these done regularly to prevent deterioration of a serious condition. The member of staff responded by saying, "I don't know". The nurse then said, "Maybe there is something in the person's notes?" The staff member again said, "I don't know". No one had checked to see if the dressings had been applied properly according to the person's needs.

One person had a history of self-injurious behaviour. We spoke with one staff member to find out how they supported the person to reduce the risk of self-injurious behaviours. The staff member did not know about the person's history, they said they had not read the person's care plan and was not aware of this person's individual mental health needs.

One person was moving to a different home during the inspection, this had been planned for three weeks. Staff said the person had been anxious about the move and changed their mind several times. When the transport arrived the nurse and acting manager needed to spend time getting all their notes ready including their medicines records so those could be passed to the staff at their new home, this caused delay for the person. This did not show that effective care had been planned or delivered to meet this person's needs.

Failure to provide person centred care and treatment to meet people's individual needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One member of staff told us about someone they supported who followed the Bahai religion. They told us they had read up on the religion to enable them to have meaningful conversations with the person. We spoke to the person to find out if their spiritual needs were being met. They said, "If possible I would like an occasional visit from a member of the Bahai faith."

We recommend that the provider reviews and supports people to meet their diverse care, cultural and spiritual needs.

Requires improvement

Is the service effective?

Most people liked the food and people were able to make choices about what they wanted to eat. People said, "The food is not too bad" and "The food is pretty good." One person said, "I hate them giving me food I don't like" and "The menu could be improved. The menu is very plain." The provider had a 'catering book' where staff recorded any comments people made about the food. We saw comments such as, 'Excellent meal' and 'The spare ribs were excellent'. People's care plans recorded their food choices and support needed to eat meals.

We observed lunch being provided. The meal was freshly cooked, well presented and looked appetising. It was hot and in sufficient amounts. Condiments were available. People made comments during the meal such as, 'Brilliant food', and one person indicated that they had enjoyed the meal when asked by staff. People were able to have second helpings and more drinks if they wished. People were consulted about menus every morning and specific requests were taken into account. One person was not able to eat the meat and was offered an alternative meal. One person had a plate guard fitted around their plate. This supported them to eat more independently and reduced the likelihood of food spilling from their plate.

People's allergies, dietary restrictions and preferences were displayed in the kitchen. There was not a choice of main meal however an alternative such as vegetarian option was cooked when people preferred this. People were supported by staff with eating and drinking when they needed encouragement. People were weighed monthly. Staff monitored and recorded people's intake of food and fluids when their appetite declined. Their weight was monitored and people were referred to health professionals if necessary such as when substantial changes of weight were noted.

One person needed support with eating as they had been diagnosed with dysphagia, which meant they had swallowing difficulties. The person had been referred to a Speech and Language Therapist (SALT) to assess their needs. Staff followed SALT guidelines which were available in the person's care plan to ensure the person's specific dietary needs were met. Information included descriptions of food textures the person could eat and foods the person should avoid eating. These instructions were available in the kitchen to enable the chef to follow safe guidelines. Staff received training in how to safely meet the person's needs. They supported the person with a modified diet. Staff said, "They eat and drink very fast. We supervise them and give them small amounts to eat and drink and always remind them to slow down." We observed a member of agency staff standing whilst supporting someone to eat. The acting manager identified this as not being best practice or effective support, they spoke to the staff member who then sat down to support the person safely.

During lunchtime, we observed someone choked on their food. The acting manager intervened and supported the person calmly and with confidence. They gave instructions to enable the person to catch their breath and ensured they flushed the food through by having enough fluids. We discussed this incident afterwards with the acting manager. They said they would monitor this person closely and refer them for a SALT assessment if needed. The acting manager spoke with the person afterwards and with staff in a handover meeting. The person said they 'felt better' and thanked the acting manager for helping them. An incident report was completed to record this event. On that occasion the acting manager acted to ensure effective care was provided and this met the person's needs.

Requires improvement

Is the service caring?

Our findings

Most people said that staff were caring and compassionate. People said, "It's good living here. Staff are brilliant. Staff are always willing to help. I feel like staff listen to me." People also said, "I love being here in this place. Staff understand me. They are patient and have a good rapport" and "Staff are always there when I need someone to talk to." They said, "The current manager is great, encouraging and supportive and the staff are great". One person said, "My heart would not be beating if it was not for these staff." One relative wrote, "We would like to thank the staff team for the support given to X since the loss of our [relative]. In particular we are very grateful for the support given to them on the day of the funeral [by the acting manager]. He provided assurance to X and was very discreet in the way he went about this."

We observed most staff to be supportive with a caring attitude. Staff gave people prompts and gentle reminders when needed and people's requests for emotional support and reassurance were met. The staff displayed a polite and respectful attitude and the care that was provided was of a kind and sensitive nature. One person who needed help because they were anxious was assisted by staff who ensured their needs were respected. A person who was unwell and who remained in their room was visited several times during the day and was asked whether they needed anything or company. There was a friendly and appropriately humorous interaction between staff and people. Staff told us that one person responded well to conversations about local news events, and liked staff to speak calmly to them. This reduced their anxiety. We observed staff engaging in such discussions with them in a calm and relaxed way. The acting manager and the nurse were particularly attentive and took time to listen and talk to people and explain things to them. The nurse said that staff knew people quite well but they didn't always sit and talk to them as the home was quite 'institutionalised' and staff had fixed ideas about the tasks they did each day. Part of delivering care to people was to sit and spend time talking with them especially when people became anxious. The nurse said, "I try to do this whenever I can". We did see a member of staff sitting chatting but other staff spent time together in the kitchen or carrying out tasks.

One person told us, "Staff are not respectful. It's their attitude." On one occasion we overheard a staff member speaking to someone in an abrupt way. The nurse said when asked about this member of staff's approach, "Well X is young." This staff interaction was not compassionate or caring and did not meet the needs of that person. We discussed this incident with the acting manager who was concerned to hear about this and said they would act swiftly to address this.

People's privacy and dignity was promoted by staff. All staff knocked on people's bedroom doors, announced themselves and waited before entering. People chose to have their door open or closed and their privacy was respected. People were assisted with their personal care needs when needed in a way that respected their dignity. A person told us, "They are respectful when I need help with washing and dressing." Staff said, "I always maintain people's dignity and respect. I support one person to take a shower and they always tell me what they want. I ask whether they want me to stay or leave and support them to wash their back." When we asked staff to give examples of how they provided care to people to promote their dignity, staff were often hesitant and unsure when responding to these questions. At lunchtime we observed one person struggling to get into the dining room with their wheelchair and one person was wheeled out of the dining room backwards which did not respect their dignity or promote their independence. The dining room was too small for the number of people and their respective mobility needs. The provider was looking to use an alternative larger room as a dining room in future.

We recommend that the provider implements further training to improve staff knowledge and competence in providing care and support to people with dignity and compassion.

A poster about advocacy services was available in the hallway to inform people about this service. Advocacy services help people to access information and services; be involved in decisions about their lives; explore choices and options; defend and promote their rights and responsibilities and speak out about issues that matter to them. Although this information was available, this was not in an accessible format. Some people were not aware of their rights, what advocacy was or how they could get support to access this service. One person said, "I don't know about advocacy. I want the advocacy number." They were keen to access advocacy to review whether they had access to correct benefits. Some people were keen to move

Requires improvement

Is the service caring?

on from the service where possible and were not sure of how they could achieve this. We discussed this with the acting manager and they said they would support people to access advocacy services if they wished.

There was limited information about the service and its facilities visible in the home. There was a notice board for people's use, however the acting manager said that people often removed information placed on this board. The provider had not explored different ways of giving people information in accessible formats. Records did not demonstrate that staff had on-going conversations with people to help them understand their rights or discuss services available to them.

We recommend that the provider explores different ways of giving people information about services available to them in accessible formats and supports people to access these services.

Staff were aware of people's interests and preferences and these were recorded in people's care plans. For example, one person liked to talk about 'James Bond' films and have discussions about films of interest. They liked reading, discussions about wildlife and liked 'spotting the moon' and birds. We observed they had binoculars with them at all times to support them to pursue their interests. Another person liked to talk about current affairs and we observed staff talking to them about a recent local news event, which the person was well informed about.

The staff promoted people's independence and encouraged people to do as much as possible for themselves. People completed their own personal care tasks when they were able to. Staff told us how they promoted the independence of someone who found social engagement difficult. They worked with them to increase their social interaction with others in the home. Previously the person had found it difficult to eat meals with others and ate meals in their own room. With support and guidance from staff they had on four occasions eaten their meal in the dining room. Staff understood their individual needs. The person had particular routines at mealtimes they liked to maintain. For example, they did not like to eat their food late and needed their food to be placed on a tray in a particular way with their medicines beside their food. Any slight change in this routine could upset their well-being. Staff were clear on the instructions around the person's routine to support their mental health and promote their independence. Recently the person had proactively requested to have supper with other people at the service. Staff said this was a positive change for the person in socially engaging with others.

One person with end of life care needs had opted to stay at the home, rather than going into hospital, this decision was made with the person and their family representative. Their preferences were recorded in their care plan. Home visits were made by a specialist nurse to support them with pain management and other care needs. A nurse provided written feedback to us, "One particular patient was dealt with by staff in a competent and compassionate way. I found the staff caring and always had the patient's best interest at heart. After long discussions with staff and relatives it was decided that in their best interest they would [have palliative care]. Staff worked hard to ensure that [the person's] comfort was paramount and they called appropriately for further visits from the surgery for advice when needed. I believe that [the person's] end of life was the best it could be due to staff diligence and care." We attended a staff handover meeting where end of life care plans were being considered for someone whose health needs had deteriorated. Staff planned to talk further with the person and their family with consent about their wishes and preferences for end of life care. However, people's end of life care preferences were not routinely recorded in their care plans.

Inadequate

Is the service responsive?

Our findings

One person told us, "I love it here. Staff get me up for my breakfast and prompt me when I need my legs dressed. I have my scooter." We observed the person used their scooter to go out in the community and they were appropriately dressed for the weather on that day. They told us they had made friends at the service and they said one person in particular was, "Like family to me, like a granddad." Other people responded, "My needs are being met" and "This place is meeting my needs." However some people said their life goals and objectives were not being met.

Peoples' care plans included their personal history and described how they wanted support to be provided. Each person had information about their likes and dislikes and preferences as to how they received support. One member of staff told us about how they sat down with someone and talked with them about how they would like to be supported. The person explained what they could do for themselves independently, but that they required assistance to put on socks and shoes and support to take a shower. However, one member of staff described the service as 'Institutional' they said, "We are trying to change it but it is difficult as most people have their routines and do not want changes." Another member of staff said, "We try to offer choice but it is hard to balance this with people's routines."

We observed the home was chaotic at times and people were frequently asking staff for help or requesting reassurance about routine and when things would happen. Staff tried to respond but it often took repeated attempts. One person became more anxious because staff seemed unable to respond to their need for a cigarette. It took three staff to go to different parts of the home and although they talked to each other, they did not inform the person that they were looking for their cigarettes. The inspector needed to try to find out where staff were, what was happening and then reassure the person. After 30 minutes a member of staff said to the person their cigarettes could not be found and they would lend them one. The person did not respond well and continued to seek help. People were often reluctant to receive the help they needed. Staff said they tried but their offer to help people maintain their personal hygiene was often refused. The nurse said that although this was the case, staff often did not encourage or support people in the way they needed. Staff accepted someone's first refusal without trying different methods to engage them. They said this led to people not receiving all their care.

People's needs had been assessed before they moved into the service in respect to their morning, afternoon, evening and night-time care. One person who had mental and physical health needs had a care plan with an assessment of their basic needs. However there was no longer term plan of care in place since the person joined the service many years previously. People's care plans did not consistently take into account their longer term goals and objectives. One person said, "I'd rather go back to the town I used to live in. I'd like to be supported in the community. I've had to start from scratch again dealing with new staff. I want to move back before my time is up." Another person said, "I don't want to be here forever. It's not really sufficient for me being here." Where people had expressed a preference to move on from the service, their goals and objectives had not been considered as part of their on-going assessment of need.

In some cases care or treatment had not been designed with a view to achieving people's preferences and ensuring their needs were met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's policy stated that people's mental health needs should be reviewed bi-monthly by a psychiatrist. For one person, the last recorded psychiatric review was dated as taking place in February 2015. This review was unsigned and no reviews had been recorded since that time. It was also unclear if this information was shared with the person in line with requirements of the Care Programme Approach (CPA). This is a system of delivering community health services to individuals diagnosed with a mental illness. This approach requires that health and social services assess the person's needs, provide a written care plan, allocate a care co-ordinator and then regularly review the plan with key stakeholders. People's care plans were not consistently reviewed to reflect any changes in people's needs or monitor progress of their goals to meet their care and treatment needs. The acting manager acknowledged formal review processes were not in place in all cases to ensure relevant healthcare professionals provided regular reviews of people needs.

Inadequate

Is the service responsive?

One person's care plan recorded that they were had specific chronic health conditions. Care reviews for this person were two months out of date. Daily records showed their health situation was deteriorating. The person declined to attend regular and required health appointments due to their mental health needs. We saw the person's G.P. had recently visited. The last care plan audit completed for this person's needs was 01 June 2015. The person was admitted urgently to hospital during our visit. The provider was responsive in referring the person to hospital to meet their immediate needs. However, there was no involvement from other health care professionals in reviewing the person's health needs in light of their on-going refusal to attend their treatments.

One person had diabetes and chose not to acknowledge their condition. The dietician had been contacted and staff attempted to explain to them the risks they were taking, but without much success. The person's health was deteriorating. We observed the acting manager reassured them and advised them of the importance of attending their health appointments. The acting manager asked the person several times over the course of the day to see whether they had changed their mind. They then arranged for the appointment to be rescheduled at the home to best meet the person's needs. However, there was no longer term care plan in place for this person in light of their on-going refusal to attend diabetes health appointments. The person's last recorded reviews were between one and three months out of date.

Other people had a history of substance and alcohol misuse and it was recognised that some people may be taking illicit substances. In these cases there was no records of involvement of relevant healthcare professionals to support people with those needs. Whilst external specialist healthcare support was available it was often only accessed as needed, rather than as a preventative measure or as part of an on-going review of people's needs. Where the responsibility for people's care and treatment was shared with other people to include health care professionals, reviews of care had not always taken place with their involvement, in a timely and formalised way taking into account preventative measures to ensure the health, safety and welfare of people.

The failure to provide safe care and treatment is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's friends and families were welcome to visit at any time and people's birthdays were celebrated. One person said, "Its okay being here. My brother comes to see me and a friend" and "I don't have any family I've made quite a few friends here"and "I get visits from friends or family" and "I have family come and see me. My family think this is the best place for me." We observed one person's family came to visit them whilst we were there. People were accompanied by staff when they requested support to go to town. This helped to reduce people's social isolation.

Most people said however there were not enough activities or opportunities to pursue hobbies and interests. Some people were able to go out independently in the community. One person said, "I go to a drop in centre at times" and "I do go out sometimes with the activities co-ordinator. I like to watch as much sport as possible" and "I go out quite a lot. I go out for a cup of tea, shopping. I go to exercise class outside on a Tuesday. I go the day centre twice a week. I can come and go as I choose. I like going to the café."

Most people said there were insufficient activities for them to take part in. They said, "There are no groups or activities going on here" and "I'd like to have a game of scrabble. Sometimes I'd like to do sewing in the evenings. I'd like to go out on day trips and have a barbeque in the garden" and "It gets lonely sometimes. I'm not really a social person" and "I've got my own TV in my room. I would be interested if they had activities. I like anything that occupies the mind. I'd like the services to have exercise classes" and "If staff could organise a coach trip I'd be interested in it" and "I'd like us to go to the pictures every now and then." Staff said, "People want to go out more. They need more things to do. We need to be more pro-active with people."

An activities co-ordinator was employed at the service. Occasionally they accompanied people to town to visit cafes and go for walks if people requested this. They bought people books and newspapers when they requested them. They showed us records when people engaged with activities. There were limited activities taking place or evidence of activities available at the service. The activities co-ordinator had only recently been instructed to record activities starting in August 2015. The acting manager said they had tried to introduce a newspaper discussion group, but people disengaged quickly from this activity. There were no games or activities options available

Is the service responsive?

for people to take part in. The acting manager said that due to people's mental health it was often difficult to engage people and often when an activity was suggested people changed their minds. The activities co-ordinator had been trying to engage people without much success, but had also been offering the same choices for some time. This was undoubtedly a difficulty due to people's mental health conditions, but because of this a more creative approach needed to be considered.

A lack of adequate activities to meet people's individual needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us people did not actively engage in consultations and therefore their preferences were not always known. Monthly house meetings had been attempted but people often chose not to attend. The provider had not identified alternative accessible means of consulting people about service delivery. Questionnaires were given to people every six months to gather their views about the service. People were specifically asked whether they had suggestions, ideas or special requests. The operations manager acknowledged that information from these questionnaires had not been analysed to review what service improvements could be made in response to people's feedback. One example identified that someone had requested to go fishing and the service was looking into obtaining a fishing licence for them. However it was not recorded as to when this would be addressed and whether this action had been completed.

People's views were sought two weeks after they came to live in the service. They were again sought at each review of their care plans. However monthly reviews were not completed in all cases, to enable this consultation to take place. The acting manager said they talked regularly with people to find out how they felt. People had attended a house meeting to discuss what people wanted on the menu. The chef attended to better understand people's food preferences. People wanted to try out some oriental foods for example. On the day of our inspection, people enjoyed a Thai curry and could have alternative options if they wanted them. Staff said, "People are consulted about things like food in house meetings, however we need to have more active engagement with people. Some people don't like talking in the meetings. I would like to use 'happy sheets' with people after meals to find out what people enjoyed. Some people like classic food and some people like to be more experimental." The provider used a 'catering book' to obtain feedback from people about food preferences they had. Whilst comments were recorded and dated in the catering book, it had not been recorded whether people's preferences had been addressed.

Failure to adequately assess, monitor and improve the quality of services to include people's views of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information leaflets were available to inform people about the complaints procedure. People were not always aware of how to make a complaint. People told us they did not have cause to complain. One person told us," I've never made a complaint. I wouldn't know how to make a complaint" and "If I wanted to make a complaint I could" and "I'm allowed choice, they do their best for me". No complaint had been received in the last 12 months before this inspection.

We recommend that the provider explores different ways of giving people information about how to make a complaint in accessible formats and supports people to make a complaint when required.

Requires improvement

Is the service well-led?

Our findings

One person said, “This place is pretty good. There is no need for improvements.” Some people commented that they had a good relationship with the acting manager and could talk to them about any issues they had. We observed people and staff to have positive communications with the acting manager. They regularly approached them to seek advice and have general conversations.

An audit system was in place to monitor service quality and identify how the service could improve. Monthly audits were completed to check the quality of care records, medicines management, infection control, and health and safety matters. However these audits were not always effective in identifying shortfalls and monitoring actions to address shortfalls. One audit identified that care plans and risk assessments were not kept up-to-date. Shortfalls in care plan information were required to be addressed by 17 June 2015. At the time of our inspection, the actions had not been recorded as completed, progress of this action had not been monitored and a date for completion had not been stated. People could not be assured that staff were meeting their care plan needs as records may not be accurate, were not regularly reviewed and updated appropriately.

As part of a fire risk audit in May 2015, it was identified that some fire doors were non-closing and needed to be re-fitted to reduce fire risks to people. The acting manager said this matter had been referred to the provider to address and they did not know when the doors would be replaced. This shortfall had not been addressed and the audit did not specify when this would be resolved. This posed a potential fire risk to people as doors may not close appropriately in the event of a fire.

Monthly infection control audits were completed to ensure the environment was safe for people to live in. However the audits did not identify shortfalls we found on the day of the inspection. For example, there was no cleaning schedule, audit or checklist for the cleaner to follow and no toilet roll and hand washing supplies in communal toilets. The risks for people were increased due to the lack of supplies and inadequate cleanliness.

The acting manager told us that maintenance work was prioritised depending on safety needs.

Some maintenance issues we identified during the inspection had not been recorded in the maintenance audit. People were at risk of sustaining injuries as these repairs had not been identified or addressed.

Staff recorded incidents and accidents when they occurred. However the acting manager acknowledged that no analysis of incidents took place to review any patterns of incidents. This meant that effective control measures may not be in place to reduce risks to people and the likelihood of incidents reoccurring.

The operations manager was responsible for implementing quality assurance audits at the service. They spent two to three days every fortnight at the service to review audits. They had delegated tasks to different staff to address shortfalls identified by the audit process. They expressed frustration that systems had not been followed through by some staff. This was in part due to recent changes in management, which had led to a period of instability at the home. Staff did not always understand their responsibilities to complete delegated tasks. The operations manager acknowledged further work was required to improve audits.

Staff meetings did not always take place regularly. Staff said, “We have meetings every two to three months. It has been a while since the last one. It is good to have meetings to find out what is happening in the home. Records of these meetings showed that staff were reminded of particular tasks and of the standards of practice they were expected to uphold. Meeting minutes recorded when an action had been identified and which staff member was responsible for the action. However, dates for completion were not clearly recorded, for example audit date comments read, ‘as soon as possible’ and ‘by the next meeting’, where no date for the next meeting had been set. It was not clear from recorded information when actions should be completed, to ensure staff had clear direction around their allocated responsibilities.

Failure to adequately assess, monitor and improve the quality of the service of is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not consistently notified the Care Quality Commission (CQC) of significant events that affected people or the service. For example on two occasions in June and July 2015 we had to prompt the provider to send

Requires improvement

Is the service well-led?

us notifications of two safeguarding incidents. In June 2015 we had to prompt the provider to send us a notification about an event that stopped the service running. This was due to a lift that required repair. The provider had not understood the need to notify us in line with their regulatory and legal obligations. The operations manager told us that managers had reviewed their responsibilities for sending statutory notifications since this was brought to their attention. They did this by reviewing provider information on the CQC website and discussing this in meetings. It was too soon to determine whether the required improvements had been made.

Failure to notify CQC of significant events at the service is a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

Communication between the acting manager, operations manager and provider was not effective. The acting manager did not have the provider's telephone number at the point of our inspection and communications took place via email. The provider, operations manager and acting manager did not collectively discuss the operational and strategic requirements of the service. The acting manager acknowledged that the service was not meeting the required regulations to the required standards.

Communications were not consistently maintained between management and staff. The acting manager had been on annual leave the week before our inspection. He informed us that staff had not completed the food order as instructed whilst he was on leave. Staff said they did not have the correct password to complete an online food order. An additional staff member needed to come in to complete the food order to ensure people had food available to eat. There was no clear protocol in place for staff to carry out operational requirements when the acting manager was not available. We observed the acting manager to be 'fire fighting' and dealing with a number of issues that staff did not feel confident to manage themselves.

The acting manager spoke to us about their philosophy of care for the service. They said "The home is institutionalised and staff are working to change this culture. We need to balance maintaining security and avoid being authoritarian, clinical, and driven by paperwork, rather than caring and nurturing." They told us they were struggling to move staff on from a task oriented approach to a more individualised approach to care. Staff said, "The vision is different depending on the person. Some people want to go out more, some people want to be more independent. People want to be happy and comfortable." Another member of staff said, "We help them to meet their basic needs and support people with their emotional needs." Staff were hesitant when asked this question and did not have a clear understanding of the philosophy of care that the organisation promoted. People may not receive consistent approaches to their care and support as staff did not always understand what they were trying to achieve with people they supported.

We observed a culture of openness at the service. The acting manager was clear about the need for person centred practice to meet people's individual needs. People and staff were welcome to come into the office to speak with them at any time. Staff were positive about the support they received and were positive about how management communicated with them. They said, "I enjoy the job and the management is great. They are supportive and approachable. I am never nervous to ask about anything" and "I feel supported. The acting manager is easy to talk with and issues are addressed."

The acting manager had researched relevant websites that included Diabetes UK, this was to obtain useful guidance in managing the health and welfare of people with diabetes. Some people's blood sugar levels had been observed to vary significantly, previously requiring the need for regular invasive blood testing. Based on research, the acting manager implemented a 'ketone' blood test system. This method reduced the need for invasive blood testing to check people's blood sugar levels. This also helped reduce the risk to people of short term health complications, illness and potential damage to organs occurring. Nursing staff were provided with relevant guidelines on what interventions were needed depending on the ketone test reading identified. This test also identified when emergency measures needed to be taken to refer people to hospital. Guidelines were included in each person's care plan where relevant. This ensured that the acting manager and staff kept informed about the latest developments in the delivery of diabetes health care in order to improve people's diabetes health care.

All the policies that we saw were appropriate for the type of service, reviewed annually, up to date with legislation and fully accessible to staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 HSCA (RA) Regulations 2014 Staffing 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons had not been deployed in order to meet the requirements of this Part. 2. Persons employed by the service provider in the provision of a regulated activity had not a. received such appropriate support, training and professional development as is necessary to enable them to carry out the duties they are employed to perform.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 1.All premises and equipment used by the service provider must be— a. clean, e. properly maintained, and 2.The registered person had not, in relation to such premises, maintained standards of hygiene appropriate for the purposes for which they are being used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 1. Care and treatment must be provided in a safe way for service users.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 1.The care and treatment of service users must— a. be appropriate, b. meet their needs, and c. reflect their preferences. 2.But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11. 3.Without limiting paragraph (1), the registered person had not routinely complied with: a. carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user; 2.Without limiting paragraph (1), the registered manager had not complied with the following: a. assessing the risks to the health and safety of service users of receiving the care or treatment; b. doing all that is reasonably practicable to mitigate any such risks; c. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; d. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; h. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; i. where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

This section is primarily information for the provider

Action we have told the provider to take

b. designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met;

c. enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment;

d. enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible;

e. providing opportunities for relevant persons to manage the service user's care or treatment;

f. involving relevant persons in decisions relating to the way in which the regulated activity is carried on in so far as it relates to the service user's care or treatment;

g. providing relevant persons with the information they would reasonably need for the purposes of sub-paragraphs (c) to (f);

4.Paragraphs (1) and (3) apply subject to paragraphs (5) and (6).

5.If the service user is 16 or over and lacks capacity in relation to a matter to which this regulation applies, paragraphs (1) to (3) are subject to any duty on the registered person under the 2005 Act in relation to that matter.

6.But if Part 4 or 4A of the 1983 Act applies to a service user, care and treatment must be provided in accordance with the provisions of that Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1.Systems or processes had not been established and operated effectively to ensure compliance with the requirements in this Part.

This section is primarily information for the provider

Action we have told the provider to take

2.Without limiting paragraph (1), such systems or processes had not enabled the registered person, in particular, to—

a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

c. maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

e. seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

f. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had failed to notify CQC of significant events at the service.