Baybury Limited

The Orchards Care Home

Inspection report

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Ratings

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

Overall summary

The Orchards Care Home provides accommodation and personal care for up to 24 older people at any one time. The home is spread over three floors and set in its own grounds. On the date of the inspection, 8 October 2014, 16 people were living in the service.

At the last inspection in December 2013 the home met all the regulations we looked at.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There was also a newly appointed home manager in place. We learnt through discussions with the two managers that the new home manager (referred to as the home manager in this report) who was responsible for day to day running of the home, was going to apply to take over the role of registered manager.

Summary of findings

We found medicines were not appropriately managed. People did not always receive their medicines at the times they needed them or in a safe way. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The premises were not managed safely. There was no disabled access in or out of the building, which put people who used wheelchairs at risk. We found some light bulbs were not working and the fire escape was partially blocked with storage. This meant people were being put at risk should they need to leave the building in an emergency. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they received good quality care from staff who knew how to care for them. We found staff were knowledgeable about the people living in the home. People spoke positively about the food on offer and we found there was a good choice of meals available.

People's needs were not always fully assessed. Care plan documentation showed people's needs were assessed prior to admission and a number of care plans were put in place to guide staff. However, work was required to make sure care plans consistently reflected people's current needs. Appropriate care was not consistently delivered such as checking people's weights in line with the requirements of their care plans. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives said the home provided good quality care and staff were kind and considerate. People described the atmosphere in the home as pleasant and, "Like a family" and said staff and management listened to and respected them. We found staff were caring and treated people with dignity and respect, provided companionship as well as assisting with care tasks.

People's capacity was not assessed under the Mental Capacity Act 2005. (MCA) We found care records did not consider people's capacity to make decisions for themselves which meant there was a risk their rights were not protected. The home had not met the requirements of the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS). Restrictions on people's liberties had not been considered despite the home restricting people's access out of the building. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Effective systems were in place to manage complaints. People reported that the home manager listened to any concerns they had and were confident they would take appropriate action.

The home manager had a clear plan in place to make improvements to the home and had identified some of the issues we found during the inspection. Staff told us the service had improved since the home manager had started with a number of positive initiatives having been put in place. We saw several improvements had been made which demonstrated to us the home manager was committed to developing the service. Further work was required to quality assurance systems and systems designed to seek feedback from people who used this service; to ensure the quality of care was consistently monitored to drive further improvement. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Improvements were required to some of the documentation used by the home namely the completion of records detailing people's daily lives and the completion of handover records. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
We found that the service was not safe.

People were not protected against the risks associated with the use and management of medicines. People did not always receive their medicines at the times they needed them or in a safe way. Medicines were not stored, administered or recorded properly.

The premises were not safely managed. There was no wheelchair access to the building which meant that wheelchair users could not safely get in or out of the premises. The fire escape was also partially blocked with stored items, risking that evacuation in the event of a fire would be compromised.

Staffing levels required improvement to ensure that there were sufficient staff to cover for staff sickness and holidays.

Is the service effective?
The service was not always effective

People told us they received good quality care from staff who knew how to care for them. We found staff were knowledgeable about the people living in the home.

People's capacity was not assessed in line with the requirements of the Mental Capacity Act 2005 (MCA). We found care records did not consider people's capacity to make decisions for themselves which meant there was a risk their rights were not being protected. The home was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) as appropriate steps had not been taken to review people's capacity and any restrictions placed on them to determine if there were any unlawful restrictions.

Appropriate action had not always been taken following weight loss to ensure the cause of this was fully investigated. This meant there was a risk people's healthcare needs were not being met.

Is the service caring?
The service was caring

People and their relatives said staff were kind, considerate and treated them well. They all said staff were friendly and provided companionship. We observed good interactions between staff and people who lived at the home and saw they were treated with dignity and respect.

People and relatives told us they felt listened to by staff and management. They said their views were respected. We saw staff understood the people they cared for including their likes and dislikes. This helped them to provide personalised care.

Is the service responsive?
The home was not always responsive.

People's needs were not always fully assessed. Although a range of care plans were in place, these often did not contain sufficient detail to ensure responsive care. We found people's weights were not always checked in line with the requirements of their care plans, which meant there was a risk weight loss would not be promptly identified.

Documentation in relation to the care people received required improvement to ensure an accurate record for each person in the home was available.

Summary of findings

An effective system was in place to manage complaints. People and relatives reported that there were sufficient activities available to do in the home.

Is the service well-led?

The service was not consistently well led.

A new manager had recently started working at the home. Staff, visitors and relatives all spoke positively about the home manager. We found they had a clear vision for improving the service and we saw evidence positive changes had been implemented.

Improvements were required to the provider's audit systems. Although some of the issues we found during the inspection had already been identified, others had not, for example failings in the medicine management system.

Work was required to seek the feedback of people who used the service to ensure care quality was regularly monitored and improved.

The Orchards Care 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7th October 2014 and was unannounced. The inspection team consisted of an adult social care inspector and a pharmacy inspector, to look in detail at the medicine management system.

We used a number of different methods to help us understand the experiences of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with six people who used the service, six relatives, four members of staff, the newly appointed home manager and registered manager. We spent time observing care and support being delivered. We looked at four people's care records and other records which related to the management of the service such as training records and policies and procedures.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information along with other information we held about the provider. We contacted the local authority safeguarding team and local healthwatch organisation to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with two health care professionals who regularly visited the service.

Is the service safe?

Our findings

As part of this inspection we looked at a sample of medicines records and stocks for ten people who lived in the home. We observed medicines being handled and talked to two care workers. Overall we found people were at risk because medicines were not always handled safely.

Medicines were not safely administered. When we observed medicines being prepared and given to people we saw safe practice was not being followed, because records and stocks were not properly checked, to help make sure the right medicines were being given at the right time. We found that medicines that should have been given before meals were always given afterwards. This meant there was risk to people's health and wellbeing.

We looked at medicines care plans and information kept with the medicines records. We found little or no information to support their safe use. Medicines for use 'when required' had no information about how to safely handle them and creams were not safely applied and recorded. Records were not well maintained, for example, there was a lack of photographs for identifying some people, no recorded allergies and handwritten records were not routinely double checked by two care workers as recommended by current care homes guidance. Medicines stocks were not always properly checked and recorded at the beginning of the current monthly medicines cycle. This meant they could not be fully accounted for so we could not be sure if people's medicines were given to them correctly.

A suitable trolley was used for storing medicines and this was secure. However, the arrangements for storing controlled drugs (medicines that are liable to misuse) were not safe. This meant there was a serious risk that controlled drugs might be mishandled and misused. During the inspection the home manager arranged for appropriate controlled drugs storage to be installed, which was in place by the end of the inspection.

There were no effective systems for auditing medicines and staff competency so managers could not be sure that care workers were safely handling medicines and that the home had appropriate safe procedures that followed current best practice guidance. We raised this with the home manager who agreed to ensure a programme of medicines audit was put in place.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the premises were not safely managed. There was no wheelchair access into the building. We had raised this with the provider during our inspection in April 2013; however, no action had been taken by the date of this inspection. We observed there was a person who lived at the home who was a wheelchair user. The home manager told us that currently it would be difficult to get that person out of the building, and for example, if an event in the garden or community was held they would not be able to attend. This showed the provider had not made reasonable adjustments to the premises to meet this persons' needs.

We found a number of light bulbs were not working on the top floor of the premises, this presented a risk to people, particularly on the back staircase where bulbs on two floors were not working meaning this area would be completely dark in the evening or at night. We found the carpet was ill-fitting in the hallway presenting a trip hazard. Three people told us they were cold during the inspection whilst they were sat in the main lounge, we checked the radiators in this area and found only one of the two was warm. There were no thermometers situated within the lounge to regularly check the temperature. We also found the fire escape corridor was partially blocked with old chairs and items stored which increased the risk people would not be able to evacuate safely in the event of a fire.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found there was an inconsistent approach to risk and incident management. Falls were recorded on accident forms, for investigation by the home manager, and intervention plans put in place to keep people safe. However, we found there was a lack of reporting and investigation of other type of incidents which put people at risk of harm. For example, we saw an incident had occurred which involved one person who lived at the service hitting out at another. This had not been reported as an incident so there was no evidence of any preventative action taken.

Risk assessments were in place, for example, for falls prevention and moving and handling to keep people safe. However, we found some risks to people had not been adequately assessed. For example, one person regularly tried to leave the premises and had been found outside on

Is the service safe?

several occasions but there was no risk assessment in place detailing how this risk was to be managed. One person used a wheelchair but there was no risk assessment detailing how they would get out of the building in an emergency, or how staff would manage the risks to their welfare associated with being restricted to the building, given that there was no disabled access into or out of the building.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Emergency arrangements and protocols needed to be clearer to assist staff. We asked a member of night staff what they would do if a medical issue arose in the night. They told us they would ring the home manager who was always on call. However, they did not mention ringing for professional advice, such as the out of hour's district nursing team or 111 service. A visiting health professional raised concerns with us that they thought staff had not always taken appropriate action in response to medical issues that had arisen at night. There was no procedure on display to assist staff in the absence of the home manager which meant there was a risk that inconsistent decisions may be made with regards to health intervention.

The home manager told us that staffing levels were currently three care staff in the morning and two in the afternoon, based on the current occupancy of 16. Staff, people and relatives reported there were usually sufficient staff on duty to meet people's needs. For example, one relative told us, "No problem at all with staff levels." On the day of the inspection, we found there were enough staff to meet people's needs and attend to people's requests. However, we found staffing levels were not consistently maintained the week before the inspection. On examining rota's we noted that when the cook had been absent a care assistant had been covering in the kitchen, but the service had not provided an additional care assistant to cover their shift. This meant there had only been two staff available in the mornings instead of three. We raised this with the home manager who confirmed this was the case and said they had made do with less staff due to a number of unplanned absences. This meant there was a risk that people's needs may not be met due to inconsistent staffing levels. A health professional we spoke with also raised concerns about staffing levels during this period and said staff had been unable to respond to their request to provide a few minutes supervision for a person as one of the care assistants was in the kitchen. We saw the service was recruiting another cook and additional care staff to reduce the likelihood of further occurrences of inconsistent staffing levels.

People told us they felt safe in the service and they said they had not witnessed anything that concerned them. They spoke positively about staff and said they kept them safe. They told us that if they did have any problems they would go to the home manager. Safeguarding procedures were in place to protect people from harm and we saw evidence they were followed in relation to concerns raised about staff. For example, we looked at how a concern raised about a staff member had been managed and found disciplinary procedures had been followed to keep people safe. Staff we spoke with had a good understanding of what constituted abuse and said the home manager would deal with any issues raised.

We saw safe recruitment procedures were in place to ensure staff were suitable for the role. This included ensuring a Disclosure and Barring Service (DBS) check and two written references were obtained before staff started work. We spoke with a new staff member who confirmed to us the relevant checks had been completed before they were offered a job.

We saw equipment was used as specified in care plans such as handling belts, hoists, wheelchairs and pressure cushions in order to keep people safe. One person told us how staff had helped them to get a new wheelchair which they were, "Very pleased" with.

Is the service effective?

Our findings

People reported that they received effective care at the service. For example, one person said, "Really happy here, they care for me well." Relatives we spoke with were all satisfied with the care provided at the home, for example one relative told us, "They always provide good care and liaise well with the nurses."

We found staff gave people the opportunity to make choices over their daily lives such as what they wanted to eat and drink and what they wanted to do within the service. However, care plans were not signed by people which meant there was no evidence they had consented to their plan of care. Decisions in relation to care and treatment were not always made in line with the Mental Capacity Act 2005 (MCA) and the service was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We reviewed five people's care records and found no mental capacity assessments were place. These included four people who staff said could become confused or had difficulty making decisions. We found the lack of assessments impacted on the care and support people received. For example, in one person's records, a care plan was in place because they did not always dress appropriately. The care plan stated staff should physically assist the person to dress if verbal prompts were ineffective. However, there was no formal assessment of their capacity to determine whether the person had capacity to make this decision for themselves. In another person's records it was unclear whether they had the capacity to make and understand decisions in relation to following instructions to reduce the risk of pressure ulcers.

Another person's records showed they had left the premises by the fire exit on several occasions and tried to get out on other occasions. There was no assessment of capacity detailing whether they had the capacity to make this decision for themselves and the manager told us no Deprivation of Liberty Safeguards (DoLS) request for authorisation had been submitted by the service. This was despite staff saying the person frequently tried to leave and they prevented them from doing so. Following the recent supreme court judgement, the service had not taken steps to review whether anyone was being deprived on their liberty and no DoLS requests for authorisations had been submitted to the local authority. Two of the three staff we spoke with said they had not undertaken training on MCA or DoLS and were unable to tell us about the legislation or how to apply it. We found training in these areas was not included as part of induction. This meant there was a risk staff would not take the correct steps to protect people's rights under the MCA.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities Regulations) 2010.

We saw evidence staff worked with healthcare professionals. For example contacting them to discuss people's healthcare concerns. Relatives we spoke with reported the staff were good at reporting any health issues to the relevant professionals. For example, one relative told us, "They are always on the ball when it comes to health, contacting the doctor with any concerns." However, we found two instances where appropriate action had not been taken to address or investigate potential healthcare needs. According to care records one person's weight had reduced by 9.2kg from February to September 2014, but there was no evidence this had been identified or investigated. We raised this with home manager who told us they had difficulty weighing this individual accurately, and whilst they believed they may have lost some weight, this reading was unlikely to be accurate. However the discrepancies had not been promptly identified by staff, which had the potential to put the person at risk. In another person's records we noted their weight had been recorded as reduced by 3kg between July 2014 and September 2014 but again no investigation had taken place. We raised this with the home manager who said they would investigate these omissions immediately. Advice from health professionals had not always been recorded in individual care plans. For example, specific advice from health professionals regarding pressure area care, although recorded in the health professionals section had not always been used to update or reformulate the care plans. This meant there was a risk that key care information was missed if staff just read the care plan. A health professional we spoke with told us that although the service was usually good at contacting them, they didn't always learn lessons and kept making similar mistakes.

Is the service effective?

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities Regulations) 2010.

Staff understood the individual needs of the people we asked them about such as the correct moving and handling procedures to follow with each person. People and relatives reported staff had the right skills and attributes to care for them and said they did an effective job. Staff had access to a range of training which was provided periodically. This included training such as safeguarding adults, moving, handling and specialist training such as skin integrity training provided by external health professionals. Medication training was provided to senior staff who administered medication. However staff had not all received training in MCA/DoLS and had a poor understanding of these topics. The provider had access to specialist resources and training through the Social Care Institute for Excellence (SCIE) and used some of this information to populate care plans to give staff expert information and guidance on how to meet people's needs, for example meeting the needs of people with dementia. Records showed staff received periodic supervision and appraisal and staff confirmed this and told us they felt well supported. We saw the attitude and behaviour of staff was monitored through the supervision and appraisal process and standards set by policies so staff knew the behavioural standards they were expected to display.

Induction training was in place for new staff this included ensuring staff were aware of the policies and procedures for example, infection control, food safety and record keeping. Staff told us induction and ongoing training was good and they were frequently provided with training updates.

People spoke positively about the meals on offer at the service. We saw people were given a choice of what food they wanted, for example there were two choices available at lunchtime and three choices in the evening. These varied over a four week cycle which provided people with a variety of options. People said they were provided with sufficient quantities and meals were of good quality. We observed the lunchtime meal and saw it was provided in an unrushed manner, with staff giving people time to eat their meals.

Throughout the day, people were regularly provided with drinks to ensure they were kept hydrated. The cook was aware of people's individual needs such as who was diabetic and who required a soft diet. They told us they were supplied with sufficient quantities of food to provide a good quality diet. Some people were on supplements and the staff were aware of who these people were. Food was also fortified, for example, with cream to give people extra calories if needed. A health professional we spoke with told us the service was good at meeting people's nutritional needs, for example fortifying food.

Nutritional risk assessments had been completed. Where people had been identified as being nutritionally 'at risk' plans had been put in place informing staff what they needed to do in order to reduce the risk. These were regularly updated and included personalised measures such as 'requires softer diet due to dentures', to help staff deliver effective care. However, we found there was no auditing of people's monthly weights to monitor whether there were any overall trends with regards to weight loss or gain in the service. This would help monitor how effective the service was at meeting people's nutritional needs.

Is the service caring?

Our findings

Feedback from people and their relatives was positive regarding the attitude, behaviour and personal attributes of staff. People said staff were kind, considerate and treated them well. For example one person said, "Staff are smashing, they are all so nice to me. We have sing songs and play games. I appreciate what they do for me." Another person said, "Its lovely, all staff are angels." Relative we spoke with told us staff were kind and caring and good at calming people who had become distressed. We spoke with a relative about end of life care. They told us staff had treated their relative with kindness and compassion and been very sensitive at the end stages of life and they couldn't have wished for better staff. Health professionals we spoke with also said they had observed staff were kind and caring when they visited the service.

Staff had a good understanding of how to ensure people's privacy and dignity and staff told us people were well looked after. Staff told us they thought people were well looked after and would have no problem recommending the service to others such as their relatives. For example one staff member told us "We work well as a team in ensuring that everyone gets everything they need."

We used the Short Observational Framework for Inspection (SOFI) to observe interactions and activities in the service. We found staff treated people with dignity and respect and displayed a caring manner. Most interactions between staff and people were positive, for example, empathising with people and smiling. Staff spoke clearly and patiently to people, for example in offering them a choice of drink or lunchtime meal. We saw staff were attentive to people's needs. For example, we observed one person knocked over a cup of tea and became distressed. Staff attended to them and cleaned up the spillage whilst reassuring the person. Staff engaged in conversation with people as well as carrying out routine care tasks helping to meet people's social needs. Staff had regard to people's dignity for example ensuring their clothes were covering them appropriately when helping them to mobilise.

People and relatives told us they felt listened to by staff and management. They said their views were respected and reported that staff listened to what they wanted and provided individualised support based on people's preferences. We saw staff asking people their opinions such as what they wanted to eat and drink and what activities they wanted to do. This indicated staff listened to people.

We saw staff respected and accommodated people's cultural needs. For example, one person for whom English was not their first language, had a care plan detailing how to communicate with them. This included some common phrases in their first language. During the inspection we saw a staff member had learnt some of these phrases and used them to provide guidance and explain what was happening such as when lunch was ready.

People's preferences and likes and dislikes were recorded in their care plans to ensure staff delivered appropriate care. Life history work had also been undertaken for some people which helped staff to gain a better understanding of people. Staff we spoke with had a good understanding of the people we asked them about, such as what they liked to do. This showed us staff understood the people they were caring for so they could provide personalised care.

The home manager told us the service had an open door policy and visitors could attend at any time, and discuss any issues with the home manager. People and relatives we spoke with confirmed this was the case and said they could visit the service whenever they wanted to.

Health and care services are legally required to make 'reasonable adjustments' for people with under the Equality Act (2010) to ensure equal and fair treatment and promote independence. However we found the lack of disabled access in and out of the building meant that the provider had not made reasonable adjustments for a person who used a wheelchair. We raised this with the manager who agreed to begin making immediate arrangements for ensuring safe wheelchair access to the building.

Is the service responsive?

Our findings

Staff were not consistently responsive to people needs. Care plan documentation was in place which showed people's needs had been assessed prior to admission in a number of areas. This was then used to populate more detailed plans of care such as for mobility, falls and nutrition. There was evidence that following falls, a prevention and intervention strategy was put in place to monitor the person and ensure appropriate care. Information was noted in care plans which provided guidance on providing specialist care to meet people's needs. For example, guidance from the Alzheimer's Society had been sourced to help staff understand the care needs of person with a specific type of dementia. This helped to ensure staff met this person's needs. Specific care plans were in place which covered some areas of care such as diabetes, and managing violence and aggression. However, people' needs were not always fully assessed to ensure appropriate care was delivered. For example, one person had a urinary catheter in situ but there was no care plan for staff on how to manage catheter care safely. A health professional we spoke with told us they had concerns that staff did not always provide appropriate catheter care.

Care plan documentation was inconsistent, for example, some people had hospital passports in place which provided key information on their needs should they need to be admitted to hospital; however, others did not. The home manager had recognised that work was required to make care plans more relevant, consistent and reflective of people's needs. They had devised new paperwork to ensure these improvements were made. There was no evidence people had contributed to their assessment or the planning of their care as these documents had not been signed. There were no care plan reviews in the files that we looked at. The manager confirmed that most people/relatives had not yet been involved in a formal care review.

In three of the five care plans we looked at people had not been weighed in line with the requirements set out in their care plan. For example, one person's care plans stated they should be weighed weekly, but only three weights had been recorded since 5th August 2014. Another person who should have been weighed monthly had been weighed on 29 September but before that there was no weight record for the previous 6 months. The home manager could not explain why these weights had not been completed. This showed appropriate care was not being delivered in line with their assessed needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2010.

Staff and management told us daily handovers took place. On the day of the inspection, staff told us the morning handover had already taken place, however, the handover documentation was not completed until after we asked if it had been completed. The home manager told us handovers should always be documented. We saw the completion of handover records was inconsistent with documentation not completed on a number of days, for example in October 2014, there were no records available five of the seven days sampled. This showed the documentation was not consistently completed in line with the provider's requirements .

Daily records were not consistently completed. For example, some staff recorded people's daily routines and activities but other staff did not record anything. The home manager told us they were in the process of trying to get all staff to record properly in the records. This meant there was not an accurate record of people's daily activities and care and support provided.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2010.

Social inclusion assessments were in place which included people's likes and preferences and how to support them to be involved in activities. We saw activities were offered to people such as visits by a 'music man', a range of arts and crafts and one to one activities such as reminiscence. Relatives told us there was regularly activities going on including entertainment, games and reminiscence. During the inspection we saw staff spent time with people both individually and as a group to provide meaningful activities.

We found complaints were appropriately managed. Systems were in place to record and take action following verbal and written complaints. People told us they were aware of how to complain. We looked at how a recent complaint had been managed and saw evidence that

Is the service responsive?

appropriate action had been taken. People who lived at the service and relatives we spoke with told us they did not have any complaints but were confident any issues raised with the home manager would be addressed.

Is the service well-led?

Our findings

People and relatives we spoke with said the home manager was pleasant and friendly and addressed any concerns they had, for example one person said, “Manager is wonderful, so nice to me.” People told us they knew who the home manager was and said they were often visible and involved in care tasks. The home manager was able to tell us in detail about daily life in the service. This showed us they had a good understanding of how the home operated.

Staff also spoke positively about the home manager and told us that improvements had been made since commenced in post in September 2014. For example, one staff member said, “Much better now, every aspect, new policies have been introduced for us to work to.” Staff reported that there was a nice atmosphere in the service and the staff team got on together. People who used the service and relatives we spoke with also said the atmosphere was good and described the home as; “Like a family.” We observed positive and friendly interactions between staff, visitors and people who used the service.

The home manager had a clear vision of the improvements they wanted to make to the service and we saw evidence they had begun making these improvements such as overhauling care plan documentation, purchasing new lifting aids and implementing a range of new policies. These included equality and diversity and dignity and respect to ensure staff were aware of the set of values they needed to work to. The home manager was open with us about the key challenges which faced the organisation and were able to confidently demonstrate what these were and how these would be addressed. Some of the care issues we had identified during the inspection such as poor recording of handovers and daily records, and lack of information in care plans had been identified by the home manager and plans were in place to address these. The service was also working through action plans set by the local authority commissioning and infection control teams to improve the service. We saw evidence some of these actions had been addressed and the home manager showed us the plans in place to address the remaining actions. This demonstrated to us the provider was committed to further improvement of the service.

However, further work was required to the quality assurance system to ensure it promptly identified and rectified all care quality issues. For example, the lack of weight recording, lack of action following weight loss and lack of mental capacity assessments had not been identified through the programme of care plan audits. Some of the premises issues we found such as a number of lights not working, a blocked fire escape and the carpet that presented a trip hazard had also not been identified through environmental checks. There were no medication audits in place which could have identified some of the risks associated with the management of medicines we found during this inspection. There was also no evidence that staffing levels were monitored against the dependency levels of people who lived at the service. This meant that if people’s needs changed, staffing levels may not be responsive to these changes.

There was no overall analysis of incidents, on a periodic basis, to look for themes and trends such as pressure areas, violence and aggression or falls. Instances where this person had left the building undetected from the building had not been reported through the provider’s incident system for analysis by management. Staff told us they now did regular checks of the fire escape; however there was no evidence of clear measures put in place to investigate the reasons behind this behaviour and protect the person from harm.

There was a lack of mechanisms in place to gain the feedback of people who used the service. The home manager told us no recent surveys had been conducted to formally gain the feedback of people who used the service or their relatives. They told us they planned to introduce these in the near future. In the care records we looked at there was no evidence of any recent care plan reviews to gain the feedback of people and/or their relatives about the quality of the care.

No recent resident/relative meetings had been held which meant there was a lack of systems to involve people in the running of the service However, we saw evidence the home manager had begun arranging a residents committee, this would meet monthly and action plans would be developed following each meeting to improve the service.

Formal staff meetings had not yet been arranged by the home manager; however staff and management confirmed they had met on an individual basis both through the supervision and appraisal process and also individual meetings to address working practices. However, the

Is the service well-led?

outcomes of these individual meetings had not been formally recorded so it made it difficult to evidence care issues had been raised with staff and their performance monitored to ensure the service continually improved.

This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities Regulations) 2010.

Some data management systems required improvement to ensure they provided clear information to help the provider monitor the effectiveness of its systems. For example, there was no training matrix which made it difficult to monitor the overall training performance; people's individual training records had to be reviewed to find this information.

The home manager showed us how they used guidance, policies and information from the Social Care Institute for Excellence (SCIE) to drive improvement and keep up with the latest developments in care. Some information in people's care plans relating to specific conditions had been sourced from this institute showing that information on best practice care had been consulted to help improve the quality of care.

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 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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines, as appropriate arrangements were not in place for the recording, handling, using, safe keeping and safe administration of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person had not ensured that service users were protected against the risks associated with unsafe or unsuitable premises as there was no access for wheelchair users and the fire escape was partially blocked with items. Adequate maintenance had not taken place putting people at risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided. This is because people's capacity had not been assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate as they had not consistently carried out a full assessment of the needs of service users nor consistently planned and delivered appropriate care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person had not ensured that that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them as there was inconsistencies in the maintenance of an accurate record of their daily lives.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not protected service users, against the risks of inappropriate or unsafe care and treatment, as it was not regularly assessing and monitoring the quality of services provided, nor identifying, assessing and managing all risks relating to the health, welfare and safety of service users. There was no consistent analysis of incidents that resulted in, or had the potential to result in, harm to a service user. The registered person was not regularly seeking the views of people who used the service and those acting on their behalf.

The enforcement action we took:
A warning notice was issued, requesting that the provider met the regulation by 6th January 2015.