Hurstcare Limited

The Hurst Residential Home

Inspection report

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Date of inspection visit: 21 & 23 February 2015
Date of publication: 16/07/2015

Ratings

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

Overall summary

We inspected The Hurst Residential Home on 21 and 23 February 2015. This was an unannounced inspection. The first day of the inspection took place at the weekend following receipt of information of concern about weekend staffing. The home was last inspected in May 2014, no concerns were identified at that time.

The Hurst Residential Home is registered to provide accommodation and support for people who experience mental health difficulties including depression, anxiety and personality disorders. The home can provide care and support for up to 29 people. There were 18 people living at the home during our inspection. Accommodation is provided over two floors with communal lounge and dining areas.

A registered manager was 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 and associated Regulations about how the service is run.

Summary of findings

Most people spoke positively about the service and commented they felt safe at the home. Our own observations and the records we looked at did not always reflect the positive comments people had made.

People's safety was compromised in a number of areas. Risk assessments were not always in place where needed. They did not always address people's changing needs or provide sufficient information for staff to support people safely. Medicines were not administered as prescribed. A lack of process and control of medicines greatly increased the risk and occurrence of errors. Staffing levels did not meet the number the home had assessed as required and some staff recruitment processes were omitted. Incident and accident information was not used proactively or always taken into account when reviewing risk assessments.

The provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements and staff were not following the principles of the MCA. We found restrictions imposed did not consider whether people could consent to these measures or if a less restrictive practice could be used. Applications for Deprivation of Liberty Safeguard authorisations were not made where needed.

Mandatory training, and other training identified as appropriate, had not been delivered to some staff. Where people needed support or would have benefitted from adapted cutlery or crockery to eat, it was not provided.

There were some positive aspects of care at the service. People gave a mixed response, but were mainly complimentary about the caring nature of the staff. Staff interactions demonstrated they had built rapports with some people and people responded to this positively. Most people and visitors told us staff were kind and compassionate and respectful. However, we found some interactions were task led and other practices did not promote people's privacy and dignity. It was not clear that people were actively involved in the planning of their care. Some people told us, and we observed, that there was a lack of meaningful activities and structure to people's days.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. Visitors we spoke with told us they were made welcome by the staff. Feedback was regularly sought from people, relatives and staff although some people and visitors were unaware of this process.

Although a quality assurance framework was in place, it was ineffective. This was because it did not provide adequate oversight of the operation of the home. The home had not met regulations and there was no management plan to drive forward improvements to the quality of the service provided.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We are taking enforcement action against Hurstcare Limited to protect the health, safety and welfare of people using this service.

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.

Risk assessments were not always in place when needed and, some of those in place, did not reflect people's changing needs or always record the measures required to keep people safe.

Medication was not suitably controlled, stored or administered.

There were not enough suitably experienced or qualified staff and recruitment processes were not correctly followed.

Staff were unclear about how to report and respond appropriately to allegations of abuse.

Areas of the home were not suitably maintained.

Is the service effective?

Inadequate

The service was not effective.

Some staff had not received training on the Mental Capacity Act 2005. Deprivation of Liberty Safeguards were not in place where needed and mental capacity assessments were not completed in line with legal requirements.

Basic training had not been delivered to some staff before they worked unsupervised. Staff were unaware of triggers and strategies to support people with behaviours that challenged.

There was no information, adaptive cutlery or crockery to support people with conditions that made it difficult for them to eat and drink.

Care plans were not in place for some people and other care plans lacked guidance and information for staff to provide safe and effective care.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some people spoke positively of the care they received; however, care practices did not always respect people's dignity and were task orientated.

People were not always involved in planning their care. Care plans did not reflect people's wishes or aspirations.

Staff interacted with people throughout our inspection, although their interaction was well intended it was not always well informed.

People and relatives gave a mixed response about the care and support provided at The Hurst Residential Home.

Summary of findings

Most people appeared comfortable with staff, relatives and people's friends told us they were made to feel welcome when they visited

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Opportunities for activities were limited; people felt there was not enough to do at the home.

There was no clear structure or plan when people required additional support for rehabilitation.

A complaints procedure in place and people felt comfortable raising any concerns or making a complaint.

People's religious and cultural needs were accommodated.

Is the service well-led?

Requires Improvement

The service was not always consistently well led.

The provider of the service was also the registered manager. The staffing structure did not support the manager, no deputy manager or heads of care were appointed.

Although some audits identified concerns, they did not identify the cause of the concern or link to a strategy to prevent them from happening again.

The vision and values of the home were not clearly defined to the staff or people living there. No management strategy was evident to maintain standards or drive forward change and improvement at the service.

People told us they had the opportunity to have their say about the service and how it was run.

The Hurst Residential 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.

The inspection took place on 21 and 23 February 2015, it was an unannounced out of hours inspection in response to receipt of information of concern. The inspection team consisted of two inspectors.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for and interacted with by staff. We looked in detail at care plans and examined records which related to the running of the service. We looked at eight care plans and four staff files as well as staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed such as audits, policies and risk assessments. We also pathway tracked some people living at the home. This is when we look at care documentation in depth and obtain people's views on their day to day lives at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked around most areas of the home including people's bedrooms, bathrooms, lounge and dining areas. During our inspection we spoke with 13 people who live at the home, six visitors, five care staff, the home's cooks, maintenance staff and the registered manager. We also spoke with one health care professional who visited the home.

We reviewed the information we held about the service. We considered information which had been shared with us by the local authority, members of the public, relatives and healthcare professionals such as a social worker. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Inadequate

Is the service safe?

Our findings

Feedback received from people was mixed. Some people told us they felt safe, but other people shared concerns with us including, "I'm scared to open my mouth and say things" and "I'm really worried about how the staff have changed." Positive comments included, "I'm happy and feel settled here" and "I feel safe, there's nothing concerning me." We found areas of practice which were not safe.

Risk assessments were not always in place when needed and, some of those in place did not reflect people's changing needs or always record the measures required to keep people safe. For example, no risk assessments were in place for two people recently admitted to the service. Unaddressed risks for one person included the effect of alcohol dependency on their medication and no support plan about another person's behaviour described in a review by the manager as 'erratic and bizarre'. Daily records showed these concerns continued to occur since the people had moved to The Hurst. Staff were not able to explain or refer to any plans in place to address these risks. A history of another person unexpectedly leaving the home and remaining absent for long time periods did not link to a risk assessment or a plan to support them to stay in the service.

Where some risk assessments were completed, they did not contain sufficient guidance for staff to recognise risks or information about what to do in an emergency. For example, a diabetes risk assessment did not indicate what a safe or usual blood sugar reading was for the person. This meant that staff would not know if a reading was too high or too low. The only guidance in their notes was what staff should do if the person's blood sugar was low; however, this was the opposite of the symptoms that the person experienced. There was no diabetes emergency plan in place. This meant that staff were reliant on emergency services if they recognised a change in the person's condition. Another person experienced epilepsy, no risk assessment or support plan was in place. Staff were unable to tell us what a typical seizure was for this person, or describe any early warning signs that may happen before a seizure.

Investigation of accidents and incidents did not reflect any learning outcomes to minimise the risk of incidents happening again. Although the home supports people with mental health difficulties, when behavioural incidents had occurred, staff did not record the trigger, action taken or whether any follow up support was required. Changes in people's behaviour may also indicate changes in their mental or physical health. The lack of information made it difficult for staff to develop behavioural management strategies to ensure that potential causes of behaviours were understood. This would have helped to ensure that people were safely and consistently supported. Investigation of incidents, particularly around behavioural incidents did not link into care planning reviews and strategy development processes.

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

Medication was not suitably controlled, administered or stored. Some prescription medicines known as controlled drugs (CD) have legal requirements for their storage, administration, records and disposal. CD are prescribed medicines used to treat severe pain, induce anaesthesia or treat drug dependence. However some people abuse them by taking them when there is no clinical reason to do so or divert them for other purposes. For these reasons, there are legislative controls. CD controls were not observed because quantities delivered, administered and the return of unused drugs were not overseen by two members of staff. This meant that staff were not safeguarded against administration errors or the risk of misappropriation or misuse of controlled drugs.

Medication Administration Records (MAR) showed unexplained gaps in the administration of medicines. Incorrect records of the amount of medication received gave the impression that one person had not received their full course of antibiotics. Another MAR showed a person had received their medicine, but it was still in its packet. Medication prescribed for sedation and anti-seizure treatment was not always administered to a person when it should have been, with no explanation given. There was no system to record the receipt or disposal of medicines. Unused medicines were stored on the floor in an open box in a vacant bedroom used as the medication room. There was no inventory of what should be in the box or checks to determine if anything was missing. One CD was stored in the open box. All staff had keys to access to this room.

We observed staff administer a person's morning medicines in the afternoon and sign the MAR to indicate

that the person had taken the medicine in the morning. As the person was also prescribed afternoon medicines, this presented a risk the person may be given their afternoon medicine without sufficient time between the doses.

Where people used homely remedies, their use had not been discussed with the person's GP. This meant that staff had not checked if the ingredients of the homely remedies interfered with prescribed medicines.

There were no controls around the administration of a prescribed fortified drink. MAR sheets were not completed when it was given. Staff told us they would not know if another staff member had given the person their drink or not. The lack of process meant an increased risk that the person would not receive the prescribed quantity.

Temperatures of medicines requiring refrigeration or being stored at room temperature were not monitored or recorded. This presented a risk that medicine stored at an incorrect temperature may become desensitised and potentially ineffective.

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

There were not enough suitably experienced or qualified staff. No robust assessment, based on the needs of people living at the home, informed decisions about the number of staff needed on duty. Staff comprised of three care staff on duty from 8am until 5pm, two staff from 5pm to 8 pm and two waking night staff. On the first day of our inspection we found one staff member was unable to work independently from other staff. This was because they were not suitably trained and required the supervision of more experienced staff. The staff rota did not take this into account; an additional member of staff was not deployed. We observed that staff interacted with people on a needs led basis. Staff were not available to spend time with people, engage in conversation or activities or accompany people who wanted to go out. Some people sat for long periods of time, disengaged, with no interaction from staff. The February 2015 staff rota showed that the home regularly operated below the minimum number of staff it had considered were required, because untrained staff were not supernumerary to staffing numbers.

A visitor told us about their relative, "We keep asking if they can be taken out, they never have been". The person believed this was due to insufficient staff. On both days of our inspection, there were insufficient trained staff to support people who wished to go outside of the home. Other people told us dinner was served at 4:30pm. People felt this accommodated the availability of the cook who left at 5pm. Some people did not mind having their dinner at that time, while other people told us it was too early.

This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected as far as practicably possible by a safe recruitment system. Providers are required to establish evidence of satisfactory conduct of previous employment and, if that employment was in a care setting, the reason why the employment ended. We found where contact information was available for some staff previously employed in care work, personal character references rather than previous employment references were held. This did not address why a person's previous employment had ended, promote the principles of a robust recruitment process or protect the interests of people living at the home.

This is a breach of Schedule 3 of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Safeguarding and whistleblowing policies and procedures were in place. Training schedules showed that safeguarding training had not been delivered to two of the three staff on duty on the first day of our inspection. Although all staff told us their induction training included safeguarding, despite prompting, some staff were unclear about how to recognise, report and respond appropriately to allegations of abuse. This presented a risk that unacceptable practices and behaviours may not be recognised by staff, challenged and reported.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

Some people told us they had confidence in the staff. They felt supported to live their lives, experiencing a good quality of life and receiving appropriate health care. Comments included, "The staff are very good" and "I have no complaints." A visitor told us "I think my relative is well looked after, the staff do a good job. They contact us if ever there is a problem." Less positive comments included "The place has gone downhill since one member of staff left" and "Getting to know new staff is a big thing to me, I find it hard, I'm not sure how well they know me." We found the service did not consistently provide care that was effective.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place are intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS should ensure that the least restrictive methods are used.

The home operated a locked front door policy, with people requiring keys to enter and leave the home. The manager told us approximately six people did not have keys and were therefore unable to leave the home. DoLS applications had not been submitted to restrict the freedom of these people. It was not evident that less restrictive practices, or mental capacity assessments to establish people's ability to consent to these measures, had been considered. This did not meet with the principles of DoLS.

People's rights to make unwise decisions (decisions that may place them at risk) were not always respected or received appropriate support. For example, several people smoked. While a smoking room was provided, staff controlled the supply of some people's cigarettes. On multiple occasions staff refused people's requests for cigarettes. There was no record that people had agreed to these restrictions, that their capacity to make such a decision was considered or evidence of 'best interests' meetings. If a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests. This is one of the principles of the MCA. The measures in place at the home did not meet the principle of the MCA because a person's agreement or lack of capacity to make such an agreement had not been established.

Where unwise decisions had been made, such as excessive consumption or dependency on alcohol, appropriate support was not in place. For example, the registered manager and staff had not worked in partnership with people and the multi-disciplinary mental health teams to help people reduce their alcohol consumption and manage their dependency more effectively. This would have supported a person's right to make an unwise decision but helped to manage associated risks.

Some staff we spoke with had some knowledge of mental capacity and deprivation of liberty issues. Staff told us some of the people supported would be unable to consent to care and treatment. The MCA requires that assessment of capacity must be decision specific and must also record how the decision of capacity was reached. We found mental capacity assessments did not always record the steps taken to reach a decision about a person's capacity and were not decision specific. This did not meet with the principles of the MCA.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had not received training to effectively support the people they looked after. For example, on both days of our inspection, none of the care staff on duty had received training about how to support people with behaviours that challenged. Records showed that some of the people supported could display behaviours that challenged, including verbal and physical aggression. We spoke with staff about the behaviours. One staff member told us, "If it goes wrong, I call another member of staff." None of the staff were able to tell us about potential triggers for people's behaviours or about any strategies and techniques used to support people when such behaviours presented. While daily notes recorded the behaviours presented, there was no commentary to identify a cause or record any support given. This lack of knowledge and training placed people and staff at risk of injury and abuse.

Care staff on duty during our inspection had not received training in nutrition, falls prevention, promoting continence, mental capacity or mental health awareness.

Inadequate

Is the service effective?

The manager had identified training in all of these areas as appropriate for staff to effectively support the people living at the home. No training had been delivered in relation to epilepsy or diabetes management, even although some people living at the home had these conditions. Staff spoken with did not have a good understanding and knowledge of monitoring people for signs or symptoms, such as changes in their behaviour, which may indicate a person's mental health needs were deteriorating. While some training had been booked, the staff on duty were not suitably trained. Regular supervision and appraisal took place, but processes failed to ensure staff were supported to acquire adequate training and skills to deliver care to an appropriate standard. People could not be assured that staff had the skills and knowledge required to appropriately deliver effective, safe care.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People gave mixed views about the food served at the home. We observed lunch and dinner service on both days of our inspection. The atmosphere was light and informal, staff dished up and brought the meals to people. People sat where they liked to have their meals, mostly in the dining area. Although there was a menu board in the dining area, it was blank and people asked staff what they were having to eat. One person told us "They give me Quorn, I don't like Quorn." However, on the days of our inspection we saw that other food was provided to this person. We were told that a dietary representative was coming to the home to help to design a specific menu, however, the person had lived at the home for two weeks and simple adjustments such as the provision of basic food items had not been made.

Some people at the home had conditions that meant it was difficult to cut food and eat, for example the loss of use or restricted use of an arm. There was no information for staff on what to do to support people with meals or special cutlery or plate guards to assist people to eat. We did not see staff offer to cut up people's meals. One person chased their food around the plate with a fork, sometimes the food fell off their fork before they could put it in their mouth or it went over the edge of the plate onto the table. No condiments were offered. If people wanted salt or pepper, they had to ask for it. When people got food on their faces, there were no napkins, only paper hand towels which people commented were "rough." People were provided with a jug of water or juice in their bedrooms. One person told us they did not have a beaker to drink from and, even if they did, the jug was heavy and too awkward for them to use because of their disability. This meant that some people did not receive appropriate food for specialist diets or necessary support to eat or drink. Where adaptive or specialist cutlery or plates would have supported some people to eat, suitable equipment was not assessed or provided.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff usually monitored people's health and well-being and kept daily notes, including any input, advice or guidance from visiting healthcare professionals such as a district nurse or care coordinator. However, we found instances of ineffective care. Examples included inaction where a nutritional screening tool had identified weight loss as a risk for one person, but no further action was taken. The person was placed at risk because a referral to a dietician had not been made, or any steps to identify other underlying health concerns that may lead to loss of weight.

Where care plans identified people were incontinent, there was no guidance for staff about promoting continence. For example, taking people to the toilet upon waking, prompting them to use the bathroom throughout the day or a plan to consider the support required. Healthcare records did not indicate if referrals had been made to specialist healthcare professionals such as a continence nurse.

One person told us "Sometimes I cry myself to sleep in pain." Although their care plan detailed they were prescribed a strong painkiller, there were no other pain management strategies, pain assessment tools or evidence of a recent medicines review. No link had been considered between pain management and their behaviour that challenged. Where a person received treatment for a form of cancer, there was no care plan to support them in their treatment or guidance for staff about the side effects they may experience.

People had not been suitably supported to experience the best possible health and quality of life outcomes.

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

Inadequate

Is the service effective?

Some people told us they could see their GP, care coordinator, psychiatrists and other healthcare professionals as needed. One person told us, “I go to the Doctors by myself, or they can come here.” Another person told us, “Staff remind me to go to the Doctors.” We saw there was a diary system in place to support this. A GP visited the service on the day of our inspection and made positive comments that their patient appeared happy and content.

Requires Improvement

Is the service caring?

Our findings

Most people told us staff were kind in their approach, that their privacy and dignity was respected and that staff were caring. Positive comments included "The carers are friendly and kind," "I think it's a good place to live" and "I feel how I am matters to the staff". One visitor told us "I am confident [relative's name] receives the best of care." However, another person's comments were less positive. These included "I feel I'm treated like a two year old" and "Sometimes I find the staff patronising."

The inspection team spent time walking round the home, sitting with people, observing care and talking. The home presented as calm and relaxing for people. People could move freely around the home, spending time in their rooms and the communal areas.

Staff interactions were compassionate and well-intended. The staff were kind in manner, caring by nature but on occasions, lacked understanding. When staff supported people, they responded promptly to requests for assistance, however, most actions were task led and we saw little other interaction between staff and people. We identified some aspects of care that impacted on people's dignity, privacy and independence which required improvement.

A care plan describes in an accessible way the services and support being provided and how people want to receive their care. They should be put together and agreed with the person involved through the process of care planning and review. However, not everybody at the home had a care plan. Of those seen there was not always evidence that people were actively involved in their care planning. Some care plans did not reflect the person's wishes, aspirations or goals. Information was not available on how the person wished to receive their care, or what aspect of their care delivery was important to them. Care plans were reviewed monthly, but we could not always see confirmation that people had been involved in their care plan review.

Some people told us this lack of detail impacted on their dignity and privacy. For example, one person told us they preferred staff the same gender as they were to support them with personal care. Nothing was recorded to reflect their preference. They said often they were supported by staff of the opposite gender. This made them feel anxious and uncomfortable. A number of people commented there were no curtains in some communal areas such as the dining room. They felt "exposed" particularly at night and compared their experience to "sitting in goldfish bowl".

People were not always supported to maintain their personal and physical appearance. One gentleman had not been supported to shave; their finger nails were discoloured and long. Their visitor told us they had asked staff to trim the person's finger nails, but this had not happened. The person agreed with what their visitor told us.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people told us they felt able to take every day risks which had helped to improve their independence. One person told us, "I'm pretty independent, I go out each day, today I am going into town for lunch". However, where some people felt too anxious to take risks, it was not evident they received appropriate support from staff. For example, care notes recorded that one person can make drinks in the kitchen, but they did not because they may find it traumatic. There was no plan in place to support them to gain confidence. This demonstrated a lack of awareness and understanding of the importance of positive risk taking and supporting people's independence. We have identified this as an area that requires improvement.

We walked around the home and looked at most of the building. Most areas of the home were recently decorated. However, in a ground floor bathroom tiles were missing from behind the bath taps and there was no fitting to hang the shower head on the wall. The window in an upstairs bathroom had a sign taped to it saying 'do not open, unsafe' and the bath in another upstairs bathroom had been removed. People we spoke with told us there were other bathrooms they could use if needed, however, the state of disrepair did not present a pleasant or well-maintained environment.

Despite the above concerns, we saw staff interacting with people in a kind and compassionate way. When talking to people, staff maintained eye contact and usually knelt down next to the person. Staff had developed rapports with

Requires Improvement

Is the service caring?

some people and these people responded to staff with smiles and sometimes shared a joke or enjoyed a laugh with them. Staff spoke positively about the home and told us they enjoyed their work.

Most people appeared comfortable with staff. When supporting people and if asking their preferences, staff did so at an appropriate pace, giving people time to form their decisions and express their views. Some staff were able to tell us about people's personalities and what they liked and didn't like. One person asked for a coffee, the staff member knew how the person preferred it and confirmed this by asking them.

Relatives and people's friends told us they were made to feel welcome when they visited and that visiting times were open and flexible. They did not raise any concerns with us about the service or care delivery. On the day of our inspection, visitors arrived at the service to celebrate a person's birthday. This was a very social occasion and enjoyed by all those attending.

Care records were stored in a locked cabinet when not in use. Information was kept confidentially. Staff understood the importance of privacy and confidentiality and there were policies and procedures to support this.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt staff were usually responsive to their needs, but felt opportunities for social engagement and stimulation could be improved. Some people felt there was little structure to their day. One person commented "I've got nothing to do. Today I got up at about 4pm to come down for dinner."

Some people we spoke with had clear ideas about what they wanted to do. Some people wanted to be out and about and they told us they were able to do this, enjoying visiting friends and family and trips into town. However, where people had interests in specific activities such as cookery and art, no support or encouragement was received. There was a need to give more opportunity for people to follow individual hobbies and interests.

Care planning should consider people's specific needs, outcome goals, recovery goals and actions needed to meet those goals. Goal setting in mental health is an effective way to increase motivation and enable people to create the changes they desire. However, we found few goal plans in place. Of those seen, it was not clear if the person had met their goal or if further work was needed in order for them to achieve the goal. Activity records for the current and previous months were not completed. Progress was unclear. There was a risk that people may not have been receiving adequate care or support which met their individual needs.

Personalised information about individual needs was recorded for most people, however, care plans lacked information about people's preferences. For example, whether they preferred support from female or male staff. Personal information about people's daily routine and what a normal day looked like for any given person was not available. Information was not readily available about how people saw their mental health and what was important to them about their treatment. For example, preference of treatment if their mental health deteriorated, or if there was any medication they would not want to be given. Information such as personal preference and choice is vital in recognising how people can remain in control of their life and regain a meaningful life despite living with a mental health need.

Although care plan reviews had taken place, as they were infrequently signed or dated, it was only through speaking with the manager that we established they undertook this process. Some of the reviews were of a clinical nature and quite rightly focused on people's mental health. However, there was often little commentary or evidence of the person's input into review processes, whether the decisions reached represented their choice and whether they understood care, treatment and support choices available to them. Some people we spoke with were unaware what their care plan was or whether they had seen it.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people using the service told us they felt able to talk to staff if something was not right. They knew how to make a complaint and said, in the first instance, they would speak to staff if they had any problems. People told us they felt confident their complaint would be taken seriously. Staff told us they had established relationships with most people and felt people would complain to them if they were not happy. However, one person commented, "A lot of people from the same family work here, who would I complain to if there was a problem with one of them. I suppose it would have to be the manager." Systems were in place to record and take action following on from written and verbal complaints. There were no complaints recorded on the day of our inspection.

People's religious and cultural needs were documented within their care plan. Staff were considerate and accommodating of people's cultural and religious needs and beliefs, and people told us the home provided access to services of various religious denominations.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post who was also the provider of the service. There was no deputy manager post. Although the manager received some management support from senior carers, there was little staff structure in place to support them in their management of administrative duties or their responsibilities as the service provider.

The quality assurance framework was not effective. Breaches of some regulations identified at previous inspections were again found to be breached, for example in relation to the safe care and treatment of people and staffing concerns. There was not a sufficiently robust management programme in place to make sure the home maintained compliance or a developed management plan to drive forward improvements to the quality of the service provided.

The manager regularly completed quality monitoring checks, however, these had not recognised or addressed many of the concerns identified during this inspection. For example a medicine audit was last completed the week before our inspection. Although it identified some concerns, no action was taken to address the issues and measures were not put in place to minimise the risk of them happening again, it was therefore ineffective. Auditing of care plan content was not evident. Quality monitoring systems had not ensured that people were protected against risks relating to inappropriate or unsafe care and support or that it was delivered within the principles of the MCA 2005.

The manager checked staff response times to call bells, but an assessment of the number of staff required, set against the support and rehabilitation needs of people, had not been undertaken and was therefore not subject to regular review.

Accidents and incidents were recorded, but lacked management oversight to ensure that they formed part of the quality assurance systems to identify trends and were reflected in behaviour management and care plan reviews.

Published material about the home described it as 'a warm and caring home, run by dedicated and experienced staff, aiming to offer residents an enabling home life, to allow growth of self respect and independence within a supportive environment.' The home did not meet its published vision. Staff were unaware of the vision. There were no established values, expected staff behaviours, regular training or management strategy to develop the statement into working practice.

The manager maintained that there was a current Landlords Gas Safety Certificate and Periodic Electrical Installation Test Certificate. The certificates produced during the inspection expired in April 2014 and January 2014 respectively. Current certificates have not been received. It was not possible to determine if gas appliances or the electrical wiring in the home met with relevant safety regulations.

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

The manager also undertook regular checks of the home environment to make sure there were no safety hazards and that equipment remained serviceable. Records showed that fire alarm and emergency lighting tests were regularly undertaken, all fire extinguishers were checked when required and suitable service contracts were in place. Portable electrical appliances were tested as needed.

People told us they had the opportunity to have their say about the service and how it was run, this happened either at one to one meetings or house meetings. Favourites food choices formed a regular topic of discussion. The home also undertook three monthly surveys and meetings for people and relatives, however, some of the visiting relatives we spoke with were unaware of this. We have identified this as an area for improvement.