Cooper Residential Homes Limited

Bethel/Bethesda Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected the service on 26 August 2016 and 1 September 2016. The first day was unannounced and the second was announced.

Bethel/Bethesda Residential Home provides care and support for up to 34 older people. At the time of our inspection 22 people were using the service. The accommodation was offered over one floor. There was a communal lounge and two dining areas. There was also a courtyard for people to use should they wish to.

At the time of our inspection there was a registered manager in place who had recently returned to work after an extended period of leave. It is a requirement that the service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People were not always supported in line with the Mental Capacity Act 2005 (MCA). People consented to their support where they could. However, the provider had not assessed people's mental capacity where this was necessary and best interest decisions were not in place. Some people did not have the capacity to make certain decisions. It was not clear how some decisions had been made and whether people should make the decision for themselves. We saw some people may have restrictions placed upon them as they were not able to go out alone and may not have had the capacity to make a decision about their safety. Applications to ensure these restrictions were lawful had not been made for all these people. Staff did not fully understand their responsibilities under the Act.

Staff understood their responsibilities to protect people from abuse and avoidable harm and to remain safe. However, the provider's policy to safeguard people was not followed on one occasion in relation to an allegation of abuse. The provider had a system for recording accidents and incidents but it did not include a robust analysis to reduce their reoccurrence where possible. Although people mainly felt safe, risks to people's health and well-being were not always regularly assessed. For example, where people were at risk of falling, staff did not always have information available to them.

The provider had not always checked the environment for risks that people could have been exposed to. Fire safety checks had not always occurred and where there were actions identified by trained professionals to protect people's safety these were not always completed. Staff did not have an emergency plan available to them to provide support to people in the event of, for example, a fire.

The provider had a suitable recruitment process in place for prospective staff which included relevant checks. However, people and staff had mixed views on whether the provider had enough staff to offer safe care. We found that on occasion people had to wait to receive care.

People received their prescribed medicines in a safe way. Staff followed national guidance when offering people their medicines and received training to understand their responsibilities. Medicines were stored appropriately. However, the provider's checks on people's medicines were not completed correctly which meant that mistakes that may have occurred would not have been picked up in a timely way.

People did not always receive care and support from staff with the appropriate knowledge and skills. Staff had received regular training in topic areas such as fire safety but not in specific conditions that people were living with including dementia. New staff did not always receive an induction when they started to work for the provider. They did not have regular meetings with a manager so that they could receive feedback and guidance on their work.

The provider had not always sought the support of specialists where there were concerns about people's nutrition and hydration. People had access to other healthcare services such as to their GP.

People had mixed views on the quality of the food and drink offered to them. Some people's nutritional preferences were recorded within their care records and we found that food was served hot.

People received support from staff who were generally kind and compassionate. Staff did not always protect their dignity and privacy. Staff were largely task focused and did not always spend time talking to people about things that mattered to them. People's care records were not always stored safely as their care records were left unattended by staff on occasion. People's friends and relatives could visit without undue restriction.

People were supported to be as independent as they wanted to be in order to retain their skills. People were not always, where they could, involved in decisions about their care. People did not have information on advocacy services available to them to support them to speak up where this may have been required.

People did not always receive care when they required it. People had not always contributed to the planning of their care where they were able to. People's care plans were not regularly reviewed and did not always contain information specific to all areas of their care requirements. People's care records were not always complete and accurate. Staff knew about some people's preferences and personal histories but did not know fully the needs of people who had recently moved into the home. Some people took part in activities that they enjoyed including gardening.

People and their relatives knew how to make a complaint. The provider had a complaints policy in place which was displayed so that people and visitors knew the process. The provider had received five complaints in the last eighteen months. However, actions were not always recorded to show how the provider was dealing with them.

The provider did not meet the requirements of their registration with the CQC. Statutory notifications about significant events that occurred at the service as required in law were not always submitted. The provider did not display their rating from the latest CQC report. This is a legal requirement to inform people about our judgement about the quality of the service provided. The provider told us they would make sure the rating was displayed.

The provider's quality checks were not always suitable to ensure people received good care. The provider had not always took action to make improvements where deficiencies were found by other professionals. The provider's own audits had not identified the range of our concerns that we found when we visited. People had opportunities to give feedback to the provider. However, actions were not always taken where

feedback was received.

Staff did not always feel supported and processes were not routinely in place to guide them and to offer feedback on their work. Staff knew how to report the inappropriate or unsafe practice of their colleagues should they have needed to.

We found breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 and of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were protected from abuse and avoidable harm by staff who knew about their responsibilities to support them to keep safe but did not always follow the provider's policy.

Risks to people's health and well-being had not always been regularly assessed.

Checks on people's medicines were not always thorough. However, people received their prescribed medicines in a safe way.

People sometimes had to wait for their care to be delivered.

The provider had a thorough recruitment process including checks on the suitability of prospective staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported in line with the Mental Capacity Act 2005. Staff did not fully understand their responsibilities under the Act.

People received support from staff who had not received regular guidance on their work. Staff did not receive training on specific conditions that people experienced.

People had mixed views on the food and drink offered to them. People had access to healthcare services although the provider had not always sought specialist support where there were concerns about people's nutrition.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and privacy was not always respected.

People's preferences were not always known by staff.

People were not always involved in making decisions about their care and support where they could. Information on advocacy services had not been made available to people.

People were mainly treated with kindness and compassion from staff.

People's independence was encouraged where this was important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not always contributed to the planning or reviewing of their support needs. People did not always receive care when they required it.

People and their relatives knew how to make a complaint. However it was not always clear what action the provider had taken.

People undertook activities based on their interests.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider did not always meet their registration requirements with Care Quality Commission.

Staff did not receive regular support.

There were opportunities for people to give suggestions about how the service could improve. However, the provider was not always taking action following the feedback received.

The provider had not regularly monitored the quality of the service to ensure it was of a good standard.

Bethel/Bethesda 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection visits took place on 26 August 2016 and 1 September 2016. The first day was unannounced and the second was announced. The inspection team included two inspectors and an expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit, 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 also reviewed the information that we held about the service to inform and plan our inspection. This included information that we had received and statutory notifications. A statutory notification contains information relating to significant events that the provider must send to us. We also contacted Healthwatch (the consumer champion for health and social care) and the local authority who has funding responsibility for some people living at the home to ask them for their feedback about the service.

We spoke with eight people who used the service and with three of their relatives. The registered manager had recently returned to work following an extended period of absence so we mainly spoke with the nominated individual (A nominated individual has responsibility for supervising the way that the regulated activity is managed). We also spoke with an assistant manager, a cook and five support staff.

We looked at the care records of five people who used the service. We also looked at records in relation to people's medicines, health and safety as well as documentation about the management of the service.

These included policies and procedures, training records and quality checks that the provider had undertaken. We also looked at three staff files to look at how the provider had recruited and how they supported their employees.

Requires Improvement

Is the service safe?

Our findings

We found one person had made a serious allegation and the nominated individual told us that staff had not acted in line with the provider's policy to protect people from abuse. This was because there was a significant delay in staff reporting the allegation to a manager. This meant that the local authority's safeguarding team and the police were not notified as soon as the allegation was made in order to investigate it. The investigation by the local authority was on-going at the time of our visit. This meant that staff had not followed guidance to keep people safe from possible or actual abuse.

This matter constituted a breach of Regulation 13: Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and well-being were not routinely assessed or reviewed. One person was at risk of damage to their skin as they spent large parts of the day and night in their bed. We saw that staff were assisting the person to change position but the recording was unclear as to what position the person was assisted to turn from and to. This meant that staff could not be certain that the person received the correct support. The nominated individual told us that they would remind staff to use the repositioning charts comprehensively in the future. We had concerns about this person's safe care and treatment. Although it had been identified in their care records that they were at risk of skin damage and they had moved into the home with a significant skin injury, there was no moving and handling care plan or guidance for staff or reposition schedule for them to follow. We also saw that the person had a hospital admission whilst living at the home which staff told us was partly due to dehydration. When we looked at the person's fluid charts we found that only small amounts of fluid had been consumed most days during the last two months. We found that a risk assessment to look at ways of reducing this person's risk of dehydration was not in place and there was no care plan to guide staff on supporting the person to eat and drink. The nominated individual told us the amount of fluid consumed was not near the target amount for this person and they would remind staff about the need to encourage the person to drink more. We shared our concerns with the local authority.

We found other risks to people's safe care and treatment. One person told us that staff did not always assist them with cleaning the personal care equipment they used. The nominated individual told us that they would speak to staff to make sure that this support was always offered. We asked if staff knew how to complete this task and we were told that they had not been offered training in this area. The nominated individual told us that they would consider this training need. At our first visit a person told us that they could not always reach their call bell as the cord was sometimes placed out of reach by care staff. The person said, "I keep asking staff to make sure it is laid across the bed but when they forget I have to get out of my chair lean across the bed and use my grabber stick to get the cord". Staff told us that this person was at risk of falling due to their mobility. The nominated individual told us that they would remind staff about the position of the cord. However, at our second visit the call bell was out of reach of the person. Another person was highlighted in their care records as at risk of falling. However, we saw that risk assessments and moving and handling guidance for staff had not been completed to consider ways of reducing the risk. This meant that the provider was not doing all that was practicably reasonable to mitigate risks to people's

health and well-being.

These matters constituted a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people's health and well-being were assessed. We saw assessments to reduce risks to people in the areas of assisting people to bathe and using their equipment. However, we found these assessments were not always specific to people's individual needs or specific risks. The nominated individual told us that they would review these to make sure they were doing everything they could to help people to remain safe.

The provider took action following an accident. We saw that medical assistance had been requested for serious accidents and the local authority had been informed. We looked at accident records and found that these were not thoroughly completed. The recording of actual injuries sustained, follow-up action required and the analysis by a manager to prevent reoccurrences wherever possible had not always occurred. We saw that there was a large number of falls that had occurred at the home. A falls audit had been undertaken by a manager but this was not robust in recording any patterns found. During our visit we were told that some assistive technology was in place to help people to remain safe. Assistive technology was used to alert staff when people who were at risk of falling got out of their bed or left their bedroom. This is so that staff can then offer support to people to remain safe. One person told us that this equipment did not always work and a staff member said, "Sometimes they don't go off. They are not reliable". Another staff member told us, "The alarm system for people. It doesn't always go off. They're meant to check it". We saw that there were no systems in place to check the effectiveness of this equipment. This meant that people were at risk of not receiving the support from staff when it may have been required.

The provider had not always regularly checked the environment and equipment to make sure that potential risks to people's health and well-being were minimised wherever possible. We saw that fire detection systems, firefighting equipment and people's equipment to help them to move had been routinely tested in line with manufacturing guidelines. However, the provider was not routinely testing the fire alarm. The nominated individual told us that this should be tested weekly but it had not been checked for four months. After our first visit we asked the nominated individual to test the fire alarm. When we revisited this had not been completed. We also saw that there was a risk assessment of the water supply and storage that had been completed by an independent contractor in February 2016. There were immediate actions to be completed. The nominated individual had not carried out the actions and advised us that nobody within the home had received training on how to do this competently. We also saw that there was clutter and rubbish stored next to two fire doors which would have caused obstructions to people should they have needed to have vacated the building in an emergency. The nominated individual told us that they would arrange for the items to be removed. When we revisited the fire doors were clear from clutter. This meant that there were risks to people's health and well-being that had not always been identified or addressed by the provider.

We saw that there were plans in place for staff to follow in the event of a fire and they had routinely practiced evacuation procedures. We also saw that people had individual plans to vacate the building in an emergency. We found these focused on each person's individual needs. However, the nominated individual could not locate the service's business continuity plan which documented alternative arrangements for staff to follow in the event of an emergency such as a shortage of staff or fire. This meant that staff did not have the required information available to them should a significant incident have occurred.

People had mixed views about the number of staff available to them to offer care and support. Some people told us that they were satisfied with the amount of staff but others said improvements could be made. One

person told us, "I do feel safe but sometimes when staff take a while to come when I have pulled the call bell I get anxious". Staff also had mixed views about the amount of staff available to people. One staff member told us, "People are still getting their care but sometimes they buzz but by the time you get to them due to being short, it's too late". The staff member stated that people had been incontinent as a result of having to wait. On the day of our visit we saw that there was not always staff readily available to assist people when they requested assistance. On three occasions we heard the nominated individual prompting staff members to answer people's call bells as they had not been answered. The nominated individual told us that at present the home was not fully occupied and they felt the number of staff was appropriate to meet people's needs.

We looked at ten people's medicine records and found these to be mainly completed accurately. Where staff had missed signing for the administration of medicines, the provider's own checking processes had identified this and taken action. Where a medicines error had occurred, the provider had taken the appropriate action. A relative told us, "There was an incident when mum was given someone else's medication, they called me, explained the situation saying they had called the doctor and she would be monitored for the next 24hrs".

Medicines were checked by a manager or senior member of staff four times a day. A staff member told us that this was to quickly identify if an error had occurred and to ensure recording was complete and accurate. However, when we looked at the records, some of these had been signed in advance of staff carrying out the check. This meant that the system would not have been effective in quickly identifying errors as the process was not followed.

People received their prescribed medicines in a safe way from trained staff who had their competency checked in the last twelve months. One person told us, "Medication is always on time and if you need pain relief you can just ask". We observed a staff member offering people their medicines and seeking their consent to administer it. We found that the staff member followed national guidance when administering medicines. For example, we saw them carefully recording the administration in people's medicine records and locked away medicines once they finished their duties. Where one person was regularly refusing their medicines, a note had been made to review their medicines with their doctor. We also saw that medicines were stored appropriately. The provider had made available to staff a medicines policy which gave them guidance on the safe handling, storage and disposal of people's medicines which staff could describe.

The provider had made available to staff a policy on protecting people from abuse. This included guidance for staff on taking action as soon as they are alerted to suspected, alleged or actual abuse. We saw that staff received regular training in protecting people from abuse. Staff were able to describe the different types of abuse and the signs and symptoms that might indicate a person was at risk of harm. One staff member told us, "I would report concerns to the manager straight away, anything I noticed that wasn't right. If nothing occurred I'd go to the Care Quality Commission (CQC) or police".

People mainly told us that they felt safe living at the service when they received support from staff. One person said, "I feel safe, I've got my own front door key (room key) and my possessions are very safe". A relative commented, "Yes I think mum is safe here the staff seem to know and understand her capabilities, and since being here she has not had a fall".

The provider had a thorough recruitment policy and process in place for prospective staff members. This policy included the provider obtaining two references for each prospective employee and a Disclosure and Barring check. The Disclosure and Barring Service helps employers to make safer recruitment decisions and aims to stop those not suitable from working with people who receive care and support. We found records

within staff files confirmed these checks had consistently taken place. This meant that people were supported by staff who had been appropriately verified.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the provider was working within the principles of the MCA and found that this did not always occur.

Some people's capacity to make decisions for themselves and to consent to their care and support had been recorded in their care plans. For one person we read, 'Ability to understand and retain and weigh choices and has capacity to make all decisions'. However, where people could not consent to their care and support the provider had not completed mental capacity assessments to determine people's capacity to understand specific decisions. The nominated individual agreed that there were five people who required mental capacity assessments due to their illness or condition. They also agreed that best interest decision meetings with significant others such as family members had not taken place for a range of significant decisions. This included where a person continually refused to take their medicines. We read in one person's care plan that their family managed their monies. However, there was no reference that the family member had been legally appointed to undertake this. The assistant manager told us they were unsure if anyone had this legal authority. This meant there were risks that people's human rights were not upheld.

Staff did not fully understand the requirements of the MCA. One staff member told us, "We can't force them to do something they don't want to at the end of the day. I don't know any more". Another said, "I don't know what they are (mental capacity assessments)". We saw that apart from the nominated individual and the registered manager, staff had not received training or guidance on their responsibilities under the Act.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS). Staff showed some understanding of when a DoLS authorisation would be needed such as if there were locks to the main door to the home that people could not use. We saw that the nominated individual had made some applications to the 'supervisory body' (the local authority) where they were seeking to deprive people of their liberty. However, the authorisations for two people were not available within their care records. This is important as they contain guidance for staff about why the application to deprive someone of their liberties had been granted as well as any conditions that must be followed. The nominated individual could not locate the authorisations when we visited. We were also concerned that the nominated individual told us that three other people required a DoLS application. This was because they lacked capacity to understand specific decisions and the provider was looking to deprive them of their liberties to maintain their safety. The nominated individual told us that they would complete the applications.

These matters constituted a breach of Regulation 11: Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by staff with the required skills and knowledge. Although staff were mainly satisfied with the training offered to them, some staff felt some specific training would benefit them. One staff member told us, "I've asked for more training on being person-centred and they said they are looking into it. I want more training on working with people with dementia". We looked at the provider's training records and saw that staff received training in topic areas such as safeguarding adults and fire awareness. However, staff had not always received training in specific conditions that people at the home were experiencing such as dementia. Some staff told us that they respected people's refusal for drinks and food. However, we saw that at least five people were often confused and may have required specific approaches from staff to encourage them to maintain good nutrition and hydration. The nominated individual told us that they were supporting more people with dementia and related conditions but had not always sought training for staff in these areas. They told us that they would review their training to look at where they needed to improve. This meant that staff did not have all of the required knowledge and skills to provide effective support to people.

Staff had not always received effective support in order to carry out their roles and responsibilities. New staff did not always complete an induction when they started working at the home. One staff member told us, "There was no induction as such, just a show around of the home". Staff records did not contain induction records and when we asked the nominated individual about this they could not confirm if they had taken place. Staff had not received regular supervision with a manager. Supervision is a process whereby staff have the opportunity to meet with a manager to receive guidance and feedback on their work. One staff member told us, "Supervisions could do with being done every six months or more". Another said, "Supervisions are very, very rare. I can't remember the last time I had one. It does bother me, there should be more. The support has lapsed". Staff supervision records showed these had occurred approximately every twelve months. The nominated individual told us that supervisions should have occurred every two or three months. This meant that staff had not received regular guidance on how to provide effective support to people.

The provider had not always sought specialist advice and guidance where there were concerns about people's eating and drinking. We saw in two people's care records that they often refused food and drink. One person was described in their care records and by staff as at a high risk of malnutrition due to the small amount of food and drink they consumed. For both of these people, there was no specific guidance in place for staff to follow to encourage them to increase their food and fluid intake. We saw that referrals to specialists such as dieticians had not been made. The nominated individual agreed that specialist advice should have been sought to make sure people had the best possible outcomes and they would take action.

People were satisfied that they received support to maintain their health. One person told us, "Yes you can see the doctor. You only have to let staff know and they can contact him. The chiropodist visits also". A relative confirmed this and said, "Mum has access to all health provisions". We saw within people's care records that people largely received support from a range of health professionals where this was required. We heard staff talk with each other about people's health and any upcoming health appointments. We also saw that for three people they received the support from district nurses where they required treatment to maintain healthy skin. In these ways people's healthcare needs were largely met.

People had mixed views about the quality of food offered to them. One person said, "The food is excellent, always get what you order, the variety isn't bad either. If you fancy something special, if you let the cook know you get it". Another told us, "There is nothing appetising, you get fed up with the same food over and over again. If you didn't like the choices I don't know what you would do". People's relatives also had mixed views on the food offered to their family members. One told us, "I have seen the food menus there is a variety. Mum has commented that the tea time meal is quite plain with just sandwiches so I bring food in for

her". On the day of out visits we saw that the menu was varied and people looked like they were enjoying their meals. Food was served hot and people were given the time they needed to enjoy their meals.

Some people had their preferences for food and drink detailed in their care records. We also read about one person's preferred time of eating. During our visits we saw that people could choose where they took their meals and a range of food and drink, based on people's preferences, were offered throughout the day. This meant that staff members understood people's preferences for food and drink although these were not always recorded in people's care records.

Requires Improvement

Is the service caring?

Our findings

Staff did not always work in ways that were caring or respectful of people. During our visits we observed that staff were mainly focused on care tasks and did not spend time sitting and chatting with people. People told us that staff did not always have time to do this. One person was heard calling out regularly for staff to spend time with them and despite reassurances from staff that they would come back to them, we continued to hear the request from the person. We saw staff sitting with the person after a significant period of time from their initial request. During a mealtime we observed that people were not asked if they were satisfied with their meals or if they required assistance. We observed the handover of information from staff leaving their shift to staff starting theirs. We found the handover to be focused on people's personal care needs. Staff did not talk about the holistic needs of people and things that mattered to them. This meant staff sometimes offered care that was focused on tasks rather than in a person-centred way.

The provider had a confidentiality policy in place for the safe handling of people's personal and private information. Staff were able to describe how to keep such information safe such as storing people's care records in lockable cupboards when not in use. However, we saw during our visits that handover notes were left unattended in dining rooms that contained sensitive information about people. Staff members told us that these records should be stored securely. This meant that people's privacy was not always maintained.

People were not always, where they could be, involved in decisions about their care. People's care records did not show how people were involved in planning their care. All of the people we spoke with had little knowledge of their care plan and could not recall their involvement. Some people told us it was important that they were involved. Staff told us that care plans were discussed with people where this was possible but they did not record that these discussions had occurred or if people did not want to be involved. We also found that information on advocacy was not available to people. An advocate is a trained professional who can support people to speak up for themselves. This meant that people may have been receiving care that was not of their choice. We spoke to the nominated individual who told us they would look into how to make improvements in this area.

Staff were able to describe some people's preferences and their personal histories. Staff members told us how one person preferred their own company and their preference for spending time in their room. The person confirmed this was accurate. However, staff did not always know details about people's specific likes, dislikes and interests, particularly for people who had recently moved into the home For example, one person had been living at the home for two months. Staff were not able to describe their interests or preferences. This meant that people did not always receive support by staff members who knew about things that were important to them.

People and their relatives generally felt that the approach from staff was kind and compassionate. One person told us, "I love it here I think the staff are very good". Another said, "Now I have got used to the individual carers I feel they are doing a good job and treat me well". A relative commented, "The care is excellent, the home feels homely and staff are always there, I can't fault it. It may not look posh but it does not matter, the care is the most important". However, one relative told us that they experienced the care for

their family member that was not satisfactory. They said, "I pulled the cord and a staff member entered the room and raising their arms the response was "What do you want me to do". I have visited and [person's name] room looks like a bomb has hit it. There has been cups and beakers not cleared away from one day to the next". When we visited, we found that the home was clean.

People were largely satisfied that staff protected their dignity. One person told us, "Staff protect my privacy and dignity by always closing curtains and doors and ask me before starting my care". We heard people referred to by their preferred names and staff knocked on people's bedroom doors before entering. When people required support to move from one position to another using their equipment, this was done in a gently and encouraging way. People's dignity was protected by staff making sure that people's clothing covered them appropriately during such transfers.

People were satisfied that they were supported to be as independent as they wanted to be. One person told us, "I feel my independence is protected as staff encourage me to carry out tasks that I am able to do". Another said, "Staff do promote my independence. It's only when new staff come and try to do things for me, but I soon sort them out". Staff described how they encouraged people to do as much for themselves for as long as they could. This meant that people were supported to retain their skills wherever possible.

People's friends and family were able to visit without undue restriction. One person told us, "Visitors can visit anytime, there's no problem". We saw visitors to the home during our visit and staff confirmed there were no restrictions on the times they could visit. This meant that people were able to maintain relationships that were important to them.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive responsive care. We saw on three occasions call bells were not answered for a long period of time meaning that people had to wait for assistance. Some people and staff told us this was a problem as sometimes there were not enough staff to respond to people's requests. We saw that people who could not request assistance spent long periods of time without staff spending time with them or enquiring if they needed assistance. Other people told us that they received a service that was responsive to their needs. One person said, "I'm happy to live here the staff treat you as an individual". Another person explained that they were interested in a particular sport and enjoyed watching it on the television. They commented that staff served their meal in their room so that the viewing was not disturbed. In these ways people did not always receive care that was responsive to their individual care requirements.

The nominated individual and registered manager told us that they carried out pre-admission assessments before people moved into the home. This is important so that the provider can be sure that it can meet people's individual needs. However, for two people who had moved into the home within the last two months, there was no pre-admission assessment in their care records to guide staff on their care and support requirements. The nominated individual told us that one had not been completed and could not locate the other. We saw that care plans for these two people were not comprehensively completed. The nominated individual told us both people's completed care plans should have been in place. This meant there was a risk that they were not receiving the care and support they required or chose. We saw examples of staff carrying out intuitive care based on their experience of caring rather than based on people's specific care requirements. For one person, they required additional assistance due to their memory difficulties and staff described occasions when this support did not always occur. This meant that people did not always receive responsive care.

People or their representatives had not always contributed to the planning of their care and support. People could not recall that they had been part of this. Some relatives told us that they should have been asked whether they wanted to contribute to their family members' care plans. One relative knew that a care plan was required but had not been asked for information about their family member. Another relative said they had given information to the provider. The nominated individual told us that they did consult with people and their families where possible but did not record that this had occurred. We found that people's care plans did not show the contribution of people or their representatives. This meant that people may have received care that was not of their choosing.

People's care records did not always contain person-centred information for staff to follow about people's care needs, preferences or routines that were important to them. We saw that people's life histories were not always completed. These are important as staff can use this information to engage with people in conversation. We also saw that three people's care plans had sections that had not been completed for significant areas of people's care. For one person the assistance they required to reposition to keep their skin healthy was not completed. Staff described how they offered care to people but were not always able to describe people's individual needs and preferences. This meant that the provider had not always made information available to staff and therefore people may not have been receiving care and support that was

specific to their preferences and care requirements.

People's care needs were not always reviewed regularly. We saw that where risks to people's health and well-being had been assessed, they had been reviewed to check that the measures the provider had in place were still appropriate. However, people and relatives we spoke with could not recall their involvement in a review of their care plan. We found that people's care records did not detail the contribution from people about their views on their care needs on a regular basis. This meant that staff did not always have up to date information and guidance about how to provide responsive support to people that reflecting people's current needs.

People's bedrooms were personalised with items that had meaning to them. We saw photographs in people's bedrooms of their families. We also saw that people had bought in their own furniture where this was important to them as well as their own television and radio. This meant that the provider had enabled people to feel at home.

People and their relatives knew how to make a complaint should they have needed to. One person told us, "If I had a complaint I would tell the girls, but I have never had to complain the staff are very good you can ask them anything". A relative said, "I know how to complain I have seen the homes policies on their website. I have never seen anything that would concern me and the manager has asked me several times if I have any concerns". We saw that the provider's complaints procedure was displayed which detailed their process should a complaint be received. This also gave details of organisations that could help people to make a complaint should they have required it. The provider had received five complaints in the last 18 months. We saw that the provider had responded to two of the complaints after a full investigation of the concerns. However, for the other three complaints there was no recorded action about what the provider had done to respond to the complainant. The nominated individual told us that they had or were being dealt with but the recording did not reflect this. They told us they would look at ways to improve this.

People were satisfied with the activities available to them. One person told us, "If I like what is on the activity programme I go but otherwise I am happy to stay in my room". Another described how they enjoyed their time taking part in the activities as well as maintaining the garden which was a hobby of theirs. We saw that some people had taken part in a local community gardening initiative which they described positively and some had been on a barge trip. We also saw people playing dominoes and where they could, spent time talking to one another. Where people spent time in their bedrooms due to their care requirements, we were told that staff spent time with them to talk with them but we did not see this during our visits. There were books and ornaments available for people to use should they have wished to. This is important for people with memory difficulties as people may want to find their own activity.

Requires Improvement

Is the service well-led?

Our findings

The nominated individual was supporting staff in the absence of the registered manager who had recently returned to work after a long absence. We found that the nominated individual did not have robust systems in place to make sure that the provider's responsibilities as part of their conditions of registration with us were met. This was because the provider had not always submitted statutory notifications to us. Statutory notifications contain information relating to significant events that the provider must send to us by law. We had not been notified about three serious injuries. We had not been informed when the provider had two authorisations in place when they were depriving people of their liberties. Where there were allegations of abuse, two notifications were not sent. When we spoke with the nominated individual they were not clear about the full range of statutory notifications that should be submitted to us. This meant that the service was not always informing us about significant events at the service.

These matters constituted a breach of Regulation 18: Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had not conspicuously displayed their rating or offered the rating on their website The nominated individual confirmed they were aware of this requirement and told us they would make the latest report available within the home and on their website.

These matters constituted a breach of Regulation 20A: Requirement as to display of performance assessments of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have suitable checks or arrangements in place to monitor and improve the quality of the service. The provider conducted a weekly check of medicines. These had highlighted some deficiencies which required improvement. However, staff told us that the results of the quality check were not used effectively to change the practice of staff where this was required. We saw that accidents and incidents were not always signed off by a manager to say that they had reviewed the information. We asked the nominated individual to review all of the accidents and incidents over the last three months to make sure they had notified the relevant authorities where necessary as the recording was not robust. An analysis of accidents and incidents to try to reduce the likelihood of their reoccurrence was not thorough. Where actions had been identified through the audit, these had not always been followed through. We saw that there were outstanding action plans in relation to the safety of the water supply at the home. The nominated individual told us the actions had not been taken that had been highlighted six months prior to our visit. We also found that the testing of the fire alarm had not occurred for four months. The concerns we found during our visits had not largely been identified by the provider. This meant that the delivery of the support people received was not routinely checked or always managed effectively.

We found that five people did not have accurate, complete or contemporaneous care records relating to

their individual needs. Where there were risks to people's health and well-being, these had not always been assessed and the appropriate care planned. People's care plans had significant omissions meaning that staff did not have guidance in order to offer safe, effective and responsive care that was based on people's preferences and care requirements. People's care records did not detail their or their representatives' involvement or contribution to the planning of their care. Furthermore, one person had incorrect guidance for staff on the level of medical intervention to be given in an emergency. Although the registered manager told us they would review this information, checks on people's care records were not occurring to highlight such inaccuracies.

These matters constituted a breach of Regulation 17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives had mixed views about whether the service was well-led. One person told us, "It's alright living here up to a point. The issues I brought up last March have not been done". A relative said, "Yes I think it is well led, mum was offered a choice of room, cleanliness is good and staff interact well with each other. I'm not saying it's perfect but nowhere is". Staff members also had mixed opinions about whether the service was well-led. One told us, "Nothing gets followed up". During our inspection we found that the service was not consistently well-led. This was because the provider's processes and procedures were not always effective in highlighting the concerns that we found.

Staff told us did not always feel supported by the provider. One staff member told us, "We get lots of criticism but little praise. It would help with morale". We saw that staff did not receive regular supervision or guidance. We did see that staff had attended regular staff meeting. These covered topic areas such as reminders for staff about the support people required and feedback from the local authority which required the provider and staff team to take action. We also saw that the provider took action where staff members were not performing to the standards expected. One staff member was taken through disciplinary procedures as their practice had not been satisfactory. However, regular checks on the day to day culture of the staff group were not in place. In these ways the support staff received was inconsistent. The provider did not always have effective processes in place to make sure that staff knew what was expected of them or opportunities to reflect upon how they could provide good quality care to people.

The provider had a statement of purpose that set out its values for how care should be delivered. However, we found that the statement of purpose required a review. This was because information within it was out of date and outlined some services that were no longer available. We also found that the provider was not following its specified aims. We read how people would be assessed prior to moving into the home. We found that two people did not have pre-admission assessments within their care records. Staff were aware of the overall aims of the service. One staff member told us, "To keep them independent and safe". We saw that these values were highlighted within the statement of purpose. However, when we visited we found that staff did not always work in ways that were consistent with these values. One person made a serious allegation to staff that had not been reported to a manager for a significant period of time.

The provider had sought feedback from people about the quality of the service. We saw that in the last 12 months 24 questionnaires had been given to people and 13 were completed. We saw that the results of these were discussed with people during residents meetings. Suggestions for improvements included the request for more physical activities. We also saw that there were regular residents meetings which family members had attended. There was feedback given about the quality of the food. However, although feedback had been sought action plans were not in place to drive improvements in the areas identified. One person told us, "There has been one (residents meeting) since I have been here, they did listen, but nothing has been done". Another person said, "Some of the action points do get done". We found that people's

relatives and staff were not routinely asked for their feedback on the quality of the service. This meant that the provider had not consistently sought feedback about how to develop and improve the service and where it had, did not always take action.

Staff knew the action to take should they have had concerns about their colleagues' practice. One staff member told us, "I'd whistle-blow, I'd tell the manager. They give you a phone number you can phone. If it was the manager there is a phone number in the office to call someone else". We saw that the provider had a whistleblowing policy in place that staff could describe. A 'whistleblower' is a staff member who exposes poor quality care or practice within an organisation. We found that the provider's whistleblowing policy had contact details available for staff that they could raise their concerns with should they have needed to, such as the local authority.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not always notify without delay significant events to the Care Quality Commission as required in the carrying on of a regulated activity. Regulation 18 (1) (2) (a,b,e) (4B) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provided had not always assessed the risks to the health and safety of people and did all that was reasonable practice to mitigate such risks. Staff providing care did not always have the necessary skills. regulation 12 (2) (a,b,c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems to protect people from allegations of or actual abuse were not always followed. Regulation 13 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have comprehensive systems and processes to assess, monitor and improve the quality and safety of the service for

	people receiving care. The provider did not always identify and assess risks to people's health and well-being. People did not always have accurate, complete and contemporaneous care records. regulation 17 (2) (a,c,c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider did not display on their website or within the service the most recent rating by the Care Quality Commission. Regulation 20A (2,3).

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 11 HSCA RA Regulations 2014 Need for consent People's consent to their care and treatment was not always considered in line with the Mental Capacity Act 2005 and staff were not fully aware of their responsibilities. Regulation 11 (1,2).

The enforcement action we took:

Issued a warning notice.