Care Quality Commission

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# Amicus Care Home

**Inspection report**

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Date of inspection visit: 2, 6 and 16 March 2015
Date of publication: 04/06/2015

## 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? | Inadequate |

## Overall summary

This inspection took place on 2, 6 and 16 March 2015 and was unannounced.

Amicus is a care home providing accommodation and personal care for up to 18 older people, some of whom were living with dementia. The service is located in Strood, Rochester, approximately half a mile from the town centre. The service was provided in a detached property with accommodation on two floors. People had a variety of needs including mobility and communication difficulties. The last inspection was carried out on 9 December 2013 when we found the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 were met.

The registered provider is an individual in day to day charge of the service and therefore the service is not subject to a condition to employ a registered manager. Registered persons have a 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

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The comments people gave us about the service they received were mixed. They were complimentary about some aspects of the service they received, particularly the caring nature of staff and the quality of meals provided. However people told us that they were often bored and that staff did not spend time chatting with them or helping them to be occupied.

People were not safeguarded against abuse. People told us that they felt the staff were skilled in keeping them safe from harm, however we found that staff did not understand how to appropriately report and respond to allegations of abuse in the service. Staff did not have access to relevant guidance to support them in recognising and responding to abuse.

People were not safeguarded against the risk of unsafe or inappropriate care. People's care plans did not provide staff with the information they needed to provide a personalised service. People's choices were not respected in relation to receiving personal care. Not all staff, particularly agency staff, knew people well. They did not know about their needs or their life history to enable them to provide the care people needed in a person centred way.

People were not safeguarded against the risk of unsafe or unsuitable premises. The risks associated with unsafe or unsuitable premises had not been assessed to ensure people were kept safe. Individual risks, such as the risk of falling, had been assessed and the registered provider had sought the advice of relevant professionals. However, accidents and incidents in the service had not been monitored to identify any patterns and improvements that could be made to reduce the risk of accidents happening again. Some staff did not know how to evacuate the building in the event of a fire or other emergency.

People were not safeguarded against the risks associated with unsafe management of medicines.

People did not always receive their prescribed medicines because there was a lack of effective systems for ordering medicines from the pharmacy.

People who use services and others were not protected against the risks of acquiring an infection. Most areas of the home were clean but there was no system in use to check that all areas of the home remained clean.

People were at risk of dehydration because they did not have clear care plans to ensure staff knew how to respond to the risks and seek medical advice when needed. People were generally, but not always, complimentary about the quality of the food provided. People that needed support to eat were delivered their meals but waited an unreasonable amount of time to receive this support.

The premises had not been assessed to ensure they met the needs of people living with dementia. Those living with dementia were at risk of social isolation because staff did not understand how to engage them in meaningful activities. People were not provided with enough appropriate activities to occupy them in a meaningful way. People told us they were bored and they would like to have more to do. There were no personalised programmes of activity for people living with dementia.

People that had made a decision about receiving life-saving treatment had not had this decision reviewed to ensure it continued to reflect their wishes.

Staff had been trained to meet people's needs. They had completed relevant qualifications in health and social care to be able to safely and effectively care for people. However, staff did not always respond to people's needs appropriately or quickly enough. For example, staff did not offer assistance to a person struggling to get out of their chair.

Most staff were respectful, kind, caring and patient in their approach and had a good rapport with people. However, we found that interactions staff had with people were focused on the care tasks they were carrying out with them, such as administering medicines and providing drinks. They spent little time talking with people in a way that acknowledged their individuality. People told us that staff did not spend much time chatting with them. The language used within people's care plans to describe their needs was not always respectful.

The culture of the service did not match the stated aims in the service brochure. People did not always have

# Summary of findings

choice and control over their care and routines in the service did not reflect their preferences. People living with dementia did not have their care planned or delivered in a personalised way. The registered provider did not have effective systems in place for checking that care reflected the vision and values of the service.

Robust records were not kept to ensure that the registered provider could monitor the delivery of care. Some records, such as policies and guidance, were not accessible to staff when they needed them.

Systems for ensuring the safety of the service were not effective and had not been checked by the registered provider. This meant that failures in the systems had placed people at risk of harm, such as infection and injury from fire and accident.

People had their physical health needs met. Consideration had been given in care planning to how people's physical health could affect their mental well-being. Staff knew how to monitor people's health needs, but there was a lack of written guidance for them to follow to ensure people received a consistent response to their needs.

People and staff felt the registered provider was approachable, but some people did not feel their complaints were taken seriously.

Safe recruitment procedures ensured that staff were suitable to work with people. There were sufficient numbers of staff employed to meet people's needs.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered provider ensured that, where there were restrictions to people's freedom and liberty appropriate applications had been made to local authority and had been authorised. This ensured people's rights were protected and they were protected from harm.

People were enabled to be as independent as they wished.

In addition to the breaches of regulation which are detailed at the back of our main report, we have also made some recommendations for the registered provider to consider for improving the service.

**We recommend that the registered provider seek guidance on people's decisions about receiving lifesaving treatment.**

**We recommend that the registered provider seek guidance on implementing care plans for monitoring health conditions such as diabetes.**

**We recommend that the registered provider seek guidance on the suitability of the premises for meeting the needs of the people using the service, taking into account relevant guidance.**

**We recommend that the registered provider seek guidance on how to engage people with dementia.**

**We recommend that the registered provider seek guidance on the use of language to describe people's needs.**

**We recommend that the registered provider seek guidance on the provision of individualised personalised care to people with dementia.**

**We recommend that the registered provider review how the outcome of complaints investigations are communicated to people.**

**We recommend that the provider seek further guidance on management and analysis of incidents and accidents in care homes.**

# 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.

People were not protected from the risk of abuse because staff did not know how to respond and did not have guidance to follow.

The provider had not ensured that people were protected against the risks associated with unsafe or unsuitable premises and equipment.

The provider had not ensured there were effective procedures in place for responding to emergencies. Staff did not know how to exit the building in the event of a fire.

People did not always receive their medicines when they needed them.

People were not protected against the risk of infection because the provider had not ensured the home was cleaned to an appropriate standard.

**Is the service effective?**

**Inadequate**

The service was not effective.

Staff had received the essential training they required to enable them to carry out their roles effectively, but some training was out of date.

The provider met the requirements of the Deprivation of Liberty Safeguards. There were procedures in place in relation to the Mental Capacity Act 2005 to ensure that people's rights were protected.

People were usually but not always provided with adequate nutrition. Staff were not provided with appropriate guidance for responding to people at risk of dehydration. People who needed support to eat did not always receive this in a timely way.

The layout of the premises did not always meet the needs of people.

**Is the service caring?**

**Requires Improvement**

The service was not consistently caring.

People were positive about the caring attitude of staff, but did not always receive their care from staff that knew and understood their history. People did not feel that staff took time to chat with them other than about care tasks.

The language used in people's records was not always respectful.

Staff respected people's right to independence.

**Is the service responsive?**

**Requires Improvement**

The service was not consistently responsive.

# Summary of findings

People's care was not always planned and delivered in a person centred way. People's needs had been assessed, but not always kept under review to identify any changes.

People did not have their social needs met and some people were at risk of social isolation.

People knew how to make a complaint and felt confident to do so, but did not experience a consistent response to resolving complaints.

**Is the service well-led?**

**Inadequate**

The service was not well led.

The provider had not ensured that the vision and values of the service were consistently put into practice.

The provider had not identified where systems for the safe and effective delivery of care had failed. The provider did not have an effective quality assurance system in place.

Staff understood their roles and had confidence to question poor practice.

The provider had not ensured that robust records relating to care delivery were maintained.

# Amicus Care Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 2, 6 and 16 March 2015. The visits on 2 and 16 March were unannounced. The visit on 06 March 2015 was announced in order to meet with the registered provider.

Amicus Care Home is registered for 18 people. There were 15 people living at the care home at the time of our inspection.

The inspection team included two inspectors, an inspection manager and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience in this inspection team had personal experience of supporting family members who used residential services for older people.

We gathered and reviewed information about the service before the inspection, which included information from the local authority and Kent Fire and Rescue Service. We looked at notifications we had received from the provider. A notification is information about important events which the provider is required to tell us about by law.

We spoke with 11 people and four relatives about their experiences of using the service. We also spoke with the registered provider, five care staff, the cook and the housekeeper. We examined records which included seven people's individual care records, two staff files, staff rotas and staff training records. We sampled policies and procedures and the quality monitoring documents for the service. We looked around the premises and spent time observing the support provided to people within communal areas of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The last full inspection was carried out on 9 December 2013 where no concerns were identified.

Inadequate

# Is the service safe?

## Our findings

People told us that they felt staff were skilled and that there were enough staff available to meet their needs. They told us that staff responded quickly when they used their buzzer. One person said, "I sometimes wait 15 minutes or more, but usually they are quite quick". Relatives we spoke with told us that they felt confident that staff knew how to keep people safe. One relative said, "I know he [their family member] is safe, I have no doubts, I have seen the way staff handle and move him". Our findings were not always consistent with people's and relative's positive views about their safety.

Staff told us that when they started working at the service the registered provider told them they should report any concerns about abuse to them. Two of the five staff we spoke with understood how to recognise and report concerns about abuse or harm to the local authority. Three staff did not know what they would do to report abuse or concerns when the registered provider was unavailable. One of these staff deputised for the registered provider so if they did not know they would be unable to guide other staff or act in the registered provider's absence. The staff did not have access to guidance related to protecting people from abuse. The guidance was locked in the registered provider's office when they were unavailable, which included our first visit to the service and the morning of our third inspection visit. When we did see the guidance it was out of date and did not contain the correct procedures for staff to follow to protect people. This meant that staff did not have access to the most relevant guidance to refer to if required in order to keep people safe. Staff had not had recent training in how to recognise abuse and act to protect people. This had been planned by the registered provider, but was yet to take place.

People were not protected from the risk of harm or abuse because staff did not know how to respond and did not have up to date guidance available to them to follow. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had not adequately identified and managed risks associated with unsuitable or unsafe premises. Radiators in areas of the building were extremely hot to touch. In one corridor there was no handrail to support people with mobility difficulties and the potential risk of people using the radiators to balance themselves and being scalded had not been assessed or managed. Staff told us that people struggled to open fire safety doors around the building as they were heavy. One member of staff told us that for some people, particularly those with mobility difficulties, this had "bruised their arms" when they had opened the door. We saw two people struggling to open the door to the toilet near to the lounge area. This placed people at potential risk of harm if they were not able to easily move around the premises in the event of an emergency.

The registered provider had completed risk assessments of individuals' bedrooms which were available to staff within the staff office. These risk assessments did not identify the specific risks to the person. For example, one person liked to have air flow in their bedroom during the night and liked to keep their sliding French doors open. The French doors did not have any safety mechanisms to prevent people getting in. The person did not have any windows in their room for an alternative means of air flow. The risk assessment for this person's bedroom had not identified the security risks for the person. The person told us that some staff supported the person to have the door ajar at night and some did not. The absence of a clear risk assessment for this led to an inconsistent approach to safety and security.

The registered provider had not ensured that people were protected against the risks associated with unsafe or unsuitable premises. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

Staff recorded and reported to the registered provider accidents that occurred in the service, such as falls. The registered provider had taken action to minimise the risk of repeated accidents and relevant health professionals had been involved where necessary. Equipment to reduce risks to individuals had been purchased, such as warning alarm mats for people who were at risk of falls. The registered provider had not developed a system for analysing patterns and trends of accidents in the service or for identifying near misses. We have made a recommendation to improve this aspect of the service.

Inadequate

# Is the service safe?

During the morning of our visit on 16 March 2015 a person became locked out of their bedroom because their room lock was faulty. Staff told us that they did not have a key to the room and would have to wait until the arrival of the registered provider who had the spare key to unlock the room. They told us they had rung the registered provider who had advised they would unlock the door when they arrived later that day. Staff did eventually arrange for the handyman to attend who was able to gain access and the person was then able to access their bedroom. The person concerned became increasingly anxious during the morning and staff were unable to assist them. We asked staff what would have happened if the room had locked when the person was still inside and they were unable to give any satisfactory answer. People were not protected against the risks of unsuitable premises because the registered provider had not ensured there were effective systems in place to respond to emergencies.

The procedure for evacuating individuals from the building in the event of the fire had been recorded and their individual needs taken into account. Staff had been made aware of these evacuation procedures through a meeting with the registered provider and they were able to describe to us the way individuals needed to be moved to evacuate the building. Although staff knew about people's specific emergency evacuation needs they did not know how to safely exit the building in the event of a fire or other emergency. On 02 March 2015, two staff we spoke with did not know how to open the fire exits in the event of an emergency. Following our visit a meeting had taken place between the provider and staff to explain how to use the exits. However on 16 March 2015 two out of three staff still did not know how to open the fire exits. These two staff had not been involved in the recent fire evacuation procedure meeting.

The registered provider had not ensured there were effective procedures in place for responding to emergencies. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

The registered provider told us that staffing levels were based on an overall analysis of the levels of support people who lived at the service needed. They said they reassessed the staffing numbers provided when people's needs changed and when people moved to or from the service. There were two staff vacancies which were being covered by agency staff. People and staff told us there were enough staff to meet people's needs. People were being helped with their personal care at times that suited their preferences and staff did not appear rushed.

The registered provider operated safe recruitment procedures. Staff files included completed application forms, which detailed staff members' educational and work histories. There was a system in place to make sure staff were not able to work at the service until the necessary checks had been made to confirm that they were suitable to work with people. Individual staff files included references and proof of identity. There was evidence that disclosure and barring service (DBS) checks had been carried out.

People were supported to manage their own medication if they wished to. An assessment of the risks had been carried out and suitable and safe storage facilities provided. However, people were not always given their medicines as prescribed and intended by their doctor. Four people had run out of a prescribed medication. Staff had recorded in the diary when people had run out of a medicine, but they told us that the registered provider usually arranged for more medication to be dispensed. Two people had been without a prescribed inhaler for two days and one person had been without medication prescribed for their anxiety for six days. Another person was prescribed a nutrition supplement, but had been unable to take it when we visited on the 16 March 2015 as the supply had run out. The registered provider told us that in these cases the system for reordering medication had failed.

The registered provider had not ensured that there was an appropriate system for obtaining people's prescribed medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

People told us the home was always clean and fresh. One person said, "The cleaner is very good, she always keeps my room nice and clean and asks me if I want any extra cleaning done". The registered provider told us that the housekeeper was supposed to use a cleaning schedule

# Is the service safe?

daily as their system for cleaning all areas. The housekeeper told us, on two of our visits, that they did not have such a schedule or system to use and they were either told daily by the registered provider about any particular jobs or they just started cleaning. We found a record of daily cleaning tasks that the housekeeper had completed until the 23 February 2015 and then this system had ceased to be used. Staff told us that the registered provider did not carry out regular checks on the standard of cleaning. One bathroom had mouldy soap dispensers and a piece of string attached to the bath plug. One bath hoist seat was rusty underneath, making it hard to keep clean, and both bath seats were dirty on the underside. These examples could potentially lead to the risk of infections and despite informing the registered manager about these following our first day of inspection on the 2 March 2015 they remained the same on the 16 March 2015. The registered provider said they were unaware that the system for daily cleaning was no longer in use and they had not checked this. The infection control policy was available only when the registered provider was at the home so staff did not have access to this guidance at all times.

The staff understood that they all had responsibilities in preventing infections and they could describe hand washing procedures. However, the soap and paper towel dispensers were empty in some areas of the service. This included the sluice room. This meant that staff could not carry out effective hand washing procedures to reduce the risk of spreading infections in the service. This placed people at risk of contracting an infection. Staff told us how they protected people from the risk of infection by using the available personal protective equipment and laundry bags and we saw these being used by staff when preparing to offer people personal care, when serving meals and when cleaning rooms.

The lack of an effective system to ensure the home was cleaned to an appropriate standard to prevent materials being contaminated was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

Inadequate

# Is the service effective?

## Our findings

People told us that staff were effective in responding to their health and nutritional needs. They said, "The staff always ask before performing any personal tasks" and "They are very good on health issues". People and their relatives were complimentary about the quality and size of the meals provided. They said, "The food is fabulous", "We have some nice food here" and "The food is best thing about this home". However, there were mixed views about whether there was sufficient choice. People told us, "The cook knows my favourites"; "It's not too bad, but we don't really have a choice", and "In terms of choice, no not really, it's always rice pudding". Records showed that a choice of meals was provided and relatives told us that their family member's were always offered an alternative if they did not like what was available.

The cook had a good understanding of individual's likes and dislikes and of any nutritional needs such as diabetes or the need for softer foods. However, people that required support to eat sometimes had to wait an unacceptable amount of time for this. One person was given their bowl of soup in their bedroom at lunchtime, but had to wait a further ten minutes for staff to arrive to help them eat it, which meant the food could be cold before they were able to eat it. Another person, who required support to eat, did not receive their meal until 40 minutes after the people who were able to eat independently. On one day of the inspection we saw that whilst people were waiting for their meals to be served and delivered one member of care staff was washing up in the kitchen and two care staff were delivering the meals. The deployment of staff was not organised in a way that responded to individual's nutritional support needs. This meant that people had to wait for unacceptable amounts of time for support to eat.

People that were at risk of malnutrition or dehydration had been referred to their GP and where necessary a dietician. Speech and language therapists had been consulted where people had difficulty swallowing. One person regularly refused meals and drinks and the registered provider had involved relevant healthcare professionals in planning their care. On 16 March 2015 this person remained in bed and staff told us at 2pm that they had refused to eat or drink that morning. Records showed that their last meal had been at breakfast the previous day, but they had received their prescribed dietary supplement. However during our visit the person was not offered a dietary supplement as staff told us they had run out of stock. No action had been taken to obtain more until we informed the registered provider when they arrived at 2.30pm. The person had not accepted fluids since 9pm the previous evening. We asked staff what action they needed to take in response to the person refusing fluids. Staff responses were inconsistent and there was no guidance for staff to follow. This left the person at risk of dehydration.

Two people's care plans stated that they should have snack trays available to them in their bedrooms as they did not often like to eat regular meals. There were no snack trays in either person's bedrooms and staff told us this did not happen as routine practice.

People did not always have their nutritional and hydration needs met. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people who were able to communicate with staff and ask for what they wanted told us that they could have a drink when they wanted. One person said, "You can have a drink whenever you wish you just have to ask; last night I had Horlicks before I went to bed" and another said, "They will always get you a cup of tea if you want one". Jugs of juice and water were available in the communal areas and people's bedrooms during all three visits we made to the service. People who were unable to ask due their health or because they were living with dementia relied on the staff to assist them to have enough to eat and drink.

Staff said they felt supported in their roles and understood what was expected of them. They had been given a job description when they started work at the service and had completed an induction that met recommended national standards. All staff had completed or were working toward a recognised qualification in health and social care. Staff had completed training relevant to their role to ensure they could care for people effectively, but there were some gaps in training and some staff had not completed training such as safeguarding recently enough to ensure they were up to date with the latest guidance. Some new staff had not yet completed training in fire safety and not all staff had

undertaken training in caring for people living with dementia. The registered provider had a plan for updating staff training for 2015. Staff had not had an appraisal of their performance since 2013.

Staff said the registered provider was "Supportive with an open door approach". Supervision meetings were held between staff and the registered provider throughout the year which were used to discuss topics such as the Mental Capacity Act 2005 (MCA) and duty of care.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people were subject to a deprivation of their liberty the registered provider had ensured that legal requirements had been complied with to ensure their rights were not compromised.

There were procedures in place and guidance in relation to the MCA, which included steps that staff should take to comply with legal requirements. We observed staff obtaining people's consent before providing support. Staff had a good understanding of the MCA and talked about how people's capacity changed on a daily basis and in relation to different decisions. The registered provider had carried out assessments of people's capacity to make specific decisions. For example a person had been assessed in relation to having the capacity to make a decision about staff checking their blood glucose levels to monitor their diabetes. As the person was not able to make their own decision about this a best interest meeting had been held to ensure a decision was made that met their needs and protected their rights.

Appropriate procedures had been followed to ensure that people's wishes in relation to receiving life-saving treatment (CPR) were recorded. CPR is a first aid technique that can be used if someone is not breathing properly or if their heart has stopped. Where people had been assessed as not being able to make their own decision about this a best interest meeting had been held to ensure their rights were protected. The recorded decisions had not always been kept under review. Some people had recorded decisions about CPR that were made in September 2013 and had not been reviewed since. This meant that people were at risk of action being taken that did not reflect their most up to date wishes. We have made a recommendation about this.

People said that staff responded to their requests to see a doctor when they needed to and one person said that the registered provider "Will take you herself if needed". Staff understood people's health needs and knew what support they needed. Consideration had been given in people's care plans as to how their physical health could impact on their mental health, for example an infection being the cause of confusion.

Where people required monitoring of their health conditions, this was done by staff who had received the necessary training, for example to test the blood glucose levels in people with diabetes. Staff on duty during the inspection knew what the levels should be for people, but there was limited written guidance within the care plans to ensure that all staff undertaking this had up to date information about what the readings should be. There was no information in the care plans about how to respond if the levels were outside of normal ranges. This meant that people may not receive a consistent response from staff to this area of their health needs. We have made a recommendation about this.

The registered provider had not assessed the environment to ensure it met the diverse needs of people. The service provided care and support to five people whose records confirmed were living with dementia. Consideration had not been given to relevant guidance about dementia friendly environments to help people find their way around. A report from a mental health team supporting a person made recommendations about signs, such as to indicate where the toilet was, but this had not been implemented. This person's care plan noted that they were often incontinent as they forgot where the toilet was. The dining room did not provide sufficient seating for everyone using the service. At the time of the inspection staff told us that some people chose to eat in their rooms or in armchairs in the conservatory. However, there was insufficient space for them to be accommodated if they changed their mind and wanted to eat in the dining room. We have made a recommendation about this.

**We recommend that the registered provider seek guidance on people's decisions about receiving lifesaving treatment.**

**We recommend that the registered provider seek guidance on implementing care plans for monitoring health conditions such as diabetes.**

Inadequate

# Is the service effective?

**We recommend that the registered provider seek guidance on the suitability of the premises for meeting the needs of the people using the service, taking into account relevant guidance.**

Requires Improvement

# Is the service caring?

## Our findings

People told us that staff treated them kindly and with compassion. They said, "The staff are lovely, I don't have a favourite as they are all great"; "Very helpful, kind and very good, not cold and distant" and "I like it here; it is the carers that really make it". Others told us that the staff "Always very nice to you" and "I am told to pull the cord anytime I need something".

Relatives and visitors to the home told us that staff were "Welcoming, friendly, courteous and polite". They said, "You can see they care for her" and "They are really kind". Relatives said that staff addressed their family member in a respectful way.

Staff who were assisting people to move safely around the home showed kindness and consideration. They helped people to walk at their own pace. However we noted that interactions staff had with people were focused on the care tasks they were carrying out with them, such as administering medicines and providing drinks. They spent little time talking with people in a way that acknowledged their individuality. People told us that staff did not spend much time chatting with them. They said, "There is a little chat but they don't sit with you" and "The carers are lovely, but they are too busy to chat". We heard friendly exchanges between staff and people although most of these related to the tasks staff were doing for people like helping them to move around or to eat meals.

Minutes of a 'Residents' meeting on 25 January 2015 noted that people had raised that care staff were too busy to be able to chat and one person said they were lonely. When we visited, people told us that this was still the case and that they had not been listened to. We have made a recommendation about this.

Staff described how they provided reassurance to people if they became distressed. People that were known to become agitated or upset during personal care had a care plan in place which instructed staff to offer the care at a later time when they may then accept. Staff were aware of this care plan and gave examples of when this had been followed.

People or their representatives had signed their care plans and people and their families had been involved in the assessment of their needs before they moved to the service.

Where people were independent in areas of their lives this had been recorded in their care plan. People told us that they could be as independent as they wished to be. One person said "I have help when I need it, staff don't interfere, if you want help they will help you but they don't push themselves and I don't want a lot of attention". Another commented, "I am quite happy to be left to it; they know that and they respect that".

The language that was used to describe people's needs in their care records was not always respectful. A person's risk assessment regarding use of a Zimmer Frame was not personalised to them and stated the hazard as 'Incompetent user falling over'. Two care plans we saw described that people would 'wander' rather than acknowledging that all people, regardless of levels of confusion, walked with their own purpose and that staff should strive to understand that need.

People said that they could have privacy in their own room or in one of two quiet rooms when seeing family and friends. People that needed personal care were provided with this in the privacy of a bathroom or their own bedroom. Staff knocked on people's doors before going in.

Staff understood the importance of keeping people's information secure and confidential. We saw that records were stored securely and staff ensured that conversations about people's needs took place in the duty office.

**We recommend that the registered provider seek guidance on how to engage people with dementia.**

**We recommend that the registered provider seek guidance on the use of language to describe people's needs.**

Requires Improvement

# Is the service responsive?

## Our findings

People told us that they had little choice about when they had a bath. One person said they had a bath once a week and would prefer this more often but said 'that would be quite a drain on the staff'. Another person told us that they were never sure whether they were going to have a bath on their usual day. They said, "When I ask, the carer always says 'well that depends' and does not give an answer". Another person said they would like a bath more frequently and had made a request for this but that nothing had happened. A further person told us they could not choose when to have their bath stating "No they say, bath tonight; so you have to strip off and have it there and then". Records of when people were supported to have a bath had been inconsistently completed. The records for three people we looked at did not record a bath in a ten day period.

The care plans were inconsistent in describing people's personal histories likes, dislikes and preferred routines. The permanent staff knew people well, but they told us that they knew about people's needs because they had worked in the service for a long time rather than through following written guidance. Staff that had worked with people for a long time were able to describe how people preferred to be cared for, including when they liked to get up and go to bed. Staff said they responded to people's preferred routines and always asked them when they wanted help with their care. Staff told us, "Yesterday one chap didn't want to get up and at lunchtime we offered him lunch but he didn't want it so we saved it for another time when he was ready." However, agency staff did not know the people they were caring for. One member of agency staff had worked in the home on one previous occasion and when asked they were unable to describe anyone's needs or their preferences. They said they relied on the other staff to tell them how to care for people. People did not always receive support that reflected their preferences.

People had their needs assessed before they moved into the service to ensure they could be met. People, and where appropriate, their family, had been involved in the assessment process. Not all the care plans and risk assessments people had in place, had been reviewed and kept up to date, We saw risk assessments in three people's records that were due to be reviewed in December 2013 and October 2014 that had not been reviewed. Staff told us that the needs of one of these people had rapidly changed recently but their care plan had not been updated to reflect the change in their care needs.

Staff did not always respond to people's needs in an appropriate or timely way. We observed one person who had been trying to get up from their armchair. They had, lost their balance and fell backward into the chair. Two staff were present in the room, but did not offer assistance. The person was helped to stand by another person who uses the service. We observed another person living with dementia trying to get up from their chair. Staff went to them and asked them where they were going. The person appeared confused and so staff sat them back down without attempting to explore their need further.

Staff did not adequately know people, their needs and their background. Two staff, including a senior carer, told us that three people using the service were living with dementia, however care records showed that five people had this recorded as a diagnosis. One person had been assessed by a specialist health care team and a recommendation had been made for the use of a life history book to help staff engage the person. Staff told us that the person did not have a life history book and we found no reference to this in the person's care plan or records.

Staff did not always respond effectively to people's individual needs. We have made a recommendation about this.

People's care plans were not always written in a way that ensured they received personalised care. Some people living with dementia had a personalised plan that gave staff information about how to respond to them if they were confused or distressed, but other people did not have this in place. One person living with dementia had a dementia information leaflet produced by the Alzheimer's society within their care plan file, but did not have a care plan in relation to the needs associated with their condition.

People had limited information within their care plans about their interests, hobbies and how they liked to occupy themselves. Where this was recorded the information had not been used to plan and deliver care. For example, one person had recorded in their plan that they liked to read the newspaper, however there was no plan in place for making this happen and the person said they did not receive a newspaper. Another person told us they passed

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on the copy they purchased to others so they were able to read. A person's care plan stated they supported a particular football team, but there was nothing in their care plan to enable the person to continue with this activity. People's care plans had not been written taking into account information about their personal histories.

People and staff told us that apart from the organised activities there was often little to occupy people's time in a way that responded to their hobbies or interests. People who were able to describe their experience of living at the home said, "I am bored there's not much to do", "We sit here every day like this" and "If there is one thing I would change I would like more entertainment and more trips out". Other people said they had to occupy themselves and enjoyed knitting, reading or watching T.V. The planned activities included a memory session once a month, a weekly music and movement session which staff said often involved a chat rather than the activity and a volunteer playing bingo with people.

People living with dementia had little or no activity to occupy their days. One person sat in their room for three hours without any social interaction or staff involvement. Another person sat in their room alone for four hours with staff only coming in to give a drink and lunch and to provide personal care. Two people's care plan said they were unable to participate in activities. There had been no exploration or innovation around helping people living with dementia to be occupied. Staff said that some people living with dementia used to be supported and encouraged to help with laying tables or cleaning but this had stopped and staff did not encourage them to be involved in everyday activities. The registered provider told us that sometimes if they went out they would invite a person to go with them and they might stop for coffee and cake. Staff did not routinely offer people the opportunity to go out from the home. Minutes of a "Residents" meeting on 25 January 2015 noted that people had requested more social activities and entertainment. The registered provider told us that they planned to increase entertainment sessions, but that this had yet to be arranged.

The examples above meant that people did not have their care planned to meet their needs or preferences. People were also at risk of becoming socially isolated with little activity to stimulate or interest them in order to meet their needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood how they could support people to make a complaint. One member of staff said that because one person may not always hear what is said they often used pen and paper to communicate and they write, 'Is everything O.K' and the person writes their response. They said if this person made a complaint they would report this immediately to the registered provider. There was a complaints, concerns and compliments procedure displayed on the noticeboard. This explained how people could make a complaint and the process that would be followed. It also included external contact numbers if people were dissatisfied with the registered provider's response. One person's care file included a note of a complaint they had made and a record that the procedure had been followed. They had received a response which they told us was to their satisfaction.

People told us they could make a complaint at any time and would feel confident speaking to the staff or the registered provider about any concerns they had. One person said, "If there is anything worrying me I can say". However there was mixed feedback about the response they received. One person said, "When I did complain the staff listened and the registered provider did put it right". Another said, "The manager [the registered provider] listens to you and then ignores what you have said". We were given three examples where people said they had made a verbal complaint but had not been given an appropriate response and no action had been taken to resolve the concern. People did not always feel that their complaints were taken seriously. We have made a recommendation about this.

People told us that they were supported to stay in contact with their relatives and friends and could make phone calls to them when they wished. Relatives told us that when they visited they were made welcome and they could spend as much time as they wished with their family member.

**We recommend that the registered provider seek guidance on the provision of individualised personalised care to people with dementia.**

Requires Improvement

# Is the service responsive?

**We recommend that the registered provider review how the outcome of complaints investigations are communicated to people.**

Inadequate

# Is the service well-led?

## Our findings

People and their relatives told us that they could see the registered provider of the service if they needed to. They said, "I do not see her much, but staff will give a message to her", "I see her quite regularly" and "She will always see you if you ask to see her and she is in". However, people did not always feel that the registered provider listened to them and responded to their complaints. Staff told us that they felt supported in their roles and said the registered provider was approachable and fair. They said that the provider operated an "open door approach".

Staff understood their responsibility to whistleblow if they had concerns about the conduct of other staff. They had access to the whistle blowing procedure in the staff room which they could use to guide their actions. Staff said they would not hesitate to inform the registered provider if they were concerned and they had confidence that they would respond appropriately to protect people from abuse or harm.

The registered provider showed us the brochure for the service which promoted the vision and values for the service as being a 'home from home' rather than an institution. However, during our inspection on all three days we found that the culture of the service was not always person centred and choice was not consistently promoted. The registered provider told us that they worked on shift at least two days a week to monitor the delivery of care and keep the vision and values under review, but they had not identified the same concerns about the culture as we found during our inspection. The brochure also described how the service strived to support people to continue with their hobbies, but we found that people's care had not been planned and delivered in a way that supported them to do this. People did not feel that they had enough to do to occupy their time.

The registered provider had completed the "My home life" course in 2012 in relation to person centred care and had available some reference material about managing the challenges people living with dementia may present. The registered provider had not assessed the environment against recommended standards to ensure it was suitable for people, in particular those living with dementia. The registered provider told us they did not feel this assessment was necessary for people currently living at the home.

On 2 March 2015 staff were unable to access some documentation including some policies and records required for the delivery of safe and effective care. This was because the registered provider was not working that day and the documentation was stored in their office which was locked. This included guidance related to protecting people from abuse and records of staff training, supervision and support. This was also the case on 16 March 2015. Staff said they required guidance to be available to them at all times rather than this being locked away and inaccessible to them.

Records about the delivery of care had not been completed consistently. We found gaps in individuals' personal care records and glucose monitoring charts. Staff told us that different staff recorded information about care delivery in different places within the care plan file. This meant that the delivery of care could not be easily reviewed or monitored by the registered provider.

Staff were not able to access all the records and documentation they needed for the delivery of the regulated activity. Records were not consistently completed to allow the registered provider to monitor the quality of care delivered. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a system for sending questionnaires to people, relatives and other stakeholders, but this had not been used recently. Questionnaires had last been sent in January 2014. There were no issues of concern raised. The registered provider had discussed with relatives whether they wished to hold relatives meetings but this had been declined. The registered provider wrote to relatives to inform them how they could contact her at any time. The registered provider had held a "Residents" meeting on 25 January 2015 where people had requested more social activities and had raised concerns about staff not having time to talk with them. These issues were reported to us by people as still being of concern when we carried out our inspection. We asked the registered provider what had been done in response to the concerns and they told us that they planned to increase visits by a musical entertainer, but that they had not done so yet.

The registered provider had not checked that systems were being used effectively. These related to the cleaning of the

Inadequate

# Is the service well-led?

home and infection control procedures, safeguarding people from abuse and safe medicines administration. There were no records to show that the registered provider had an effective system for regularly checking the safety or the suitability of the premises. The registered provider had not adequately identified and managed risks associated with unsafe equipment. On the 09 March 2015 the safety strap which was used to ensure people were at less risk of falling when using the stair lift was broken and staff assisted people without this essential safety measure being used. We informed the registered provider who told us they were unaware this was broken. The staff told us it had been broken for some time and, although they normally report items that required repair, no members of staff were sure if this had been reported. In response to our reporting this fault to the registered manager and not through their own safety checks a new strap had been fitted by the time we returned on the 16 March 2015 so people were able to use the stair lift safely.

The registered provider did not have effective systems in place for monitoring the quality and safety of the service that took into account the views of people that used it. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had not developed a system for analysing patterns and trends of accidents in the service or for identifying near misses. We have made a recommendation to improve this aspect of the service.

**We recommend that the provider seek further guidance on management and analysis of incidents and accidents in care homes.**

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>People's care had not been planned to meet their needs or preferences. People were at risk of becoming socially isolated with little activity to stimulate or interest them in order to meet their needs. Regulation 9(3)(b) |

| 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<br><br>People were not protected from the risk of harm or abuse because staff did not know how to respond and did not have up to date guidance available to them to follow. Regulation 13(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs<br><br>People who use services were not protected against the risks of dehydration by means of the provision of suitable hydration in sufficient quantities to meet their needs. Regulation 14 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>People who use services were not protected against the risk of unsafe or inappropriate care or treatment because robust records were not maintained. Records could not be located promptly when required. Regulation 17(2)(c) |

This section is primarily information for the provider

# Action we have told the provider to take

The registered provider did not have effective systems in place for monitoring the quality and safety of the service that took into account the views of people that used it. Regulation 17(2)(a)

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The registered provider had not ensured that people were protected against the risks associated with unsafe or unsuitable premises. Regulation 12(2)(d)<br><br>The registered provider had not ensured there were effective procedures in place for responding to emergencies. Regulation 12 (2)(a)(b)<br><br>People who use services were not protected against the risks associated with unsafe management of medicines because the systems in place to obtain people's prescribed medicines had failed. Regulation 12(2)(f)<br><br>People who use services and others were not protected against the risks of acquiring an infection by means of an effective system for preventing the spread of infection and appropriate standards of cleanliness and hygiene of the premises and equipment. Regulation 12(2)(h) |

**The enforcement action we took:**
We issued a warning notice in respect of this breach of regulation.