Hope Cottage Limited

Hope Cottage Limited

Inspection report

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Ratings

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

Overall summary

This unannounced inspection of Hope Cottage Limited took place on 18 and 19 December 2014.

Located in a residential area of Southport and near to local facilities, Hope Cottage is a residential care home providing accommodation and personal care for up to 26 people living with dementia. Accommodation is provided over two floors with a passenger lift available for access to the upper floor. All shared areas are on the ground floor, including three lounge areas, a dining room and a large conservatory at the back of the home that leads into a courtyard and garden.

A registered manager was not in post as they had left the service shortly before the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the staffing levels were inadequate to ensure people's safety was maintained at all times. For example, the dining room was left unattended at breakfast and lunchtime while staff were attending to individual

Summary of findings

people's needs. This placed some people at risk of falling when they tried to get up from their chair unsupported. Furthermore, people did not receive an adequate level of support with eating their breakfast and lunch. You can see what action we told the provider to take at the back of the full version of this report.

Regularly reviewed risk assessments were in place for each person. People who experienced falls or were at risk to falls had been referred to the local 'Falls team'.

Medication was managed in a safe way and we observed staff administering it to people safely. Two people received their medication covertly. Staff informed us the GP had agreed this but no information was in place to support this agreement. You can see what action we told the provider to take at the back of the full version of this report.

Staff were not clear about what constituted an adult safeguarding concern and a recent serious allegation had not been appropriately reported as a safeguarding matter. Fifty per cent of the staff team had not received adult safeguarding awareness training. You can see what action we told the provider to take at the back of the full version of this report.

Safe recruitment practices were in place. Staff received regular supervision and appraisal. Staff training was not current or up-to-date. You can see what action we told the provider to take at the back of the full version of this report.

Arrangements were in place to monitor the safety of the environment. Fire evacuation plans were not in place for the people living at the home and we made a recommendation regarding this. Furthermore, improvement was needed in relation to infection prevention and control and we also made recommendation in relation to this issue.

People had access to health care when they needed it, including their GP, dentist, optician and chiropodist. A visiting GP told us staff responded promptly to people's changing health care needs.

Staff had not received awareness training regarding the Mental Capacity Act (2005) and had a limited understanding of how it applied in practice. Some people who lacked mental capacity used bedrails and the use of this equipment had not been agreed through a best interest discussion or meeting. You can see what action we told the provider to take at the back of the full version of this report.

Staff were caring and kind in the way they supported people. They treated people with compassion and respect. They ensured people's privacy when supporting them with personal care activities.

Information about people's personal histories was not outlined in the care records, which meant no information was available about the person's relationships, working life or hobbies for staff. Care plans were individualised to people's current health care needs. People's food preferences and preferred daily routines were documented in the care records.

CCTV had recently been installed at the home and this had been done in line with good practice guidance. Families had been consulted. Arrangements were in place to ensure the security of the CCTV footage.

Male care staff regularly worked at the home without the presence of a female member of staff. The care records informed us that some of the women living at the home had a preference for care provision by female staff. You can see what action we told the provider to take at the back of the full version of this report.

Records showed that very little recreational or social activities had taken place throughout December 2014. Activities were not person-centred but took place based on the availability of staff. We made a recommendation regarding this.

A complaints procedure was displayed and families we spoke with were aware of how to make a complaint about the service. Families had the opportunity to participate in an annual feedback survey about the service.

The registered manager had recently left the service. The registered manager from one of the provider's other locally registered care homes had transferred across four weeks previously to manage the service. The provider (owner) acknowledged that recent audit activity within the home had identified shortcomings in the service and

Summary of findings

a development plan had been put in place to address these issues. At the time of the inspection, the provider had already started to make changes in accordance with the development plan.

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?
The service was not safe.

Although medication was administered safely, correct procedures had not been followed for administering covert medication.

Staffing levels were inadequate to ensure the safety of the people living at the home.

Arrangements to ensure people were safeguarded against the risk of abuse were not robust.

Effective arrangements were in place for the recruitment of staff.

The safety of the environment was reviewed on a regular basis but fire evacuation plans were not in place for people living there.

Inadequate

Is the service effective?
The service was not effective.

People had access to health care when they needed it, including their GP, dentist, optician and chiropodist. A visiting GP told us staff responded promptly to people's changing health care needs.

Staff received regular supervision and appraisal but their training was not up-to-date.

There was insufficient staff support at meal times to ensure people received support with their meal and had adequate to eat and drink.

Staff had not always adhered to the principles of the Mental Capacity Act (2005).

Inadequate

Is the service caring?
The service was not always caring.

Staff were caring and kind in the way they supported people. They treated people with dignity and respect. They ensured people's privacy when providing support with personal care activities.

There was no information in the care records about people's relationships, working life, hobbies and interests to support unfamiliar staff with getting to know each person.

CCTV had recently been installed and this had been done in line with good practice guidance so that people's privacy and dignity was ensured.

Requires Improvement

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

Requires Improvement

Summary of findings

Male staff were providing support to women who lived at the home even though it was recorded that they preferred female staff to provide personal care.

Families told us they were kept informed of changes to their relative's needs but this was not routinely recorded in the care records.

Families were aware of how to make a complaint and were invited to contribute to an annual feedback survey about the service.

Recreational activities were not person-centred as they took place based on staff availability rather than the needs of people living at the home.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager had recently left the service. A registered manager from one of the provider's other locally registered care homes had transferred across four weeks previously to manage the service.

The provider acknowledged that there were shortcomings in the service and a development plan had been put in place to address these issues. At the time of the inspection, the provider had already started to make changes in accordance with the development plan.

Hope Cottage Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 unannounced inspection was undertaken by one adult social care inspector on 18 and 19 December 2014.

We had not asked the provider to submit a Provider Information Return (PIR) prior to the inspection. A PIR 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. Before our inspection we reviewed the information we held about the home. We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service to obtain their views and took into account the local authority contract monitoring reports.

During the inspection we spent time with seven people who lived at the home and spoke with two family members who were visiting at the time of the inspection. We spoke with the provider, manager of the home, facilities organiser, the chef, housekeeper, two senior care workers and four care staff. We sought the views of a GP who was visiting the home at the time of our inspection.

We looked at the care records for six people who were living there, three staff recruitment files and records relevant to the quality monitoring of the service. We looked round the home, including some people's bedrooms, bathrooms, the dining room and lounge areas. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

Inadequate

Is the service safe?

Our findings

The people living at the home had needs associated with memory loss so were unable to verbally share with us whether they felt safe in the way they were supported by staff. For this reason we spent periods of time throughout the inspection observing how staff supported people. People were comfortable and at ease with staff. They readily and confidently engaged with staff.

We spoke with two family members who were visiting at the time of the inspection. Both were satisfied that their relatives were safe living at the home. They did not feel they could comment on staffing levels. However, one family member said, "Staff are always around when I come in."

There was a consistent view expressed by day and night staff that the staffing levels were inadequate to ensure the safety of people at all times. There were 18 people living at the home at the time of the inspection. Staff described the people living there as having 'high dependency needs'. Staff had a good knowledge of each person's risks and the measures they took to minimise risks. They identified that five people who liked to walk about the building were at risk of falling. Two of these people had been referred to the local 'Falls team' following a number of recent falls. Three people were cared for in bed and needed regular support from two members of staff at the same time. In addition, some of the people displayed challenging behaviour to other people living at the home. Furthermore, one person sought regular staff input by frequently ringing the call bell. The care record we looked at confirmed what staff were telling us in terms of people at risk to falls and the actual impact of people's challenging behaviour on others. We asked the manager how staffing levels were decided and were informed that a specific process was not in place to assess the dependency of people living at the home in order to determine safe staffing levels.

We were advised by staff that there were usually three care staff and a manager on duty during the day and two waking staff with a sleep-in staff at nights. The manager told us a large number of staff had recently left and on occasions the home had been unable to secure a sleep-in but had access to the sleep-in staff in another of the provider's homes located very near to Hope Cottage.

From our observations there was not enough staff on duty during the day. For example, in the morning one of the staff was supporting people in their bedrooms, another was administering medication and the third member of staff was supporting people in the dining room with breakfast. The staff member had to leave the dining room on a number of occasions to respond to the call bell and to support someone with using the toilet. As the dining room was unattended by staff we had to intervene to prevent a person from falling who was trying to get up from their chair.

Again at lunch time, and for similar reasons described above, the dining room was left unattended for short periods. This placed some people who were trying to get up from their chair at risk of falling. About 11.30 am we observed the lounge areas were unattended for at least 10 minutes. This happened because one of the staff was with the district nurse, another was supporting a person who was cared for in bed and the third member of staff was supporting a person to use the toilet. Staff told us the lounge areas were often left unsupervised whilst the staff were seeing to individual people's needs.

Not having sufficient staffing levels at all times to ensure people's safety was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The six care records we looked at showed that a range of risk assessments had been completed depending on people's individual needs. These included a falls risk assessment and a skin integrity assessment, and they were reviewed on a monthly basis. Two of the people living at the home had bedrails in place. Staff confirmed these were used to keep people safe by preventing falls from the bed. Bedrails were reviewed under the 'Room risk assessment' but the assessment lacked detail in terms of identifying any specific risk for the person using this equipment. Although bedrails are used to reduce the risk of falls from bed, they can introduce other types of serious risks particularly for people living with dementia. A risk assessment is important as it can assist with identifying other potential risks in order to decide whether bedrails are suitable for the person. The manager said they would ensure these assessments were completed in more detail.

A process was established for recording accidents and incidents. A separate process was in place for monitoring episodes of challenging behaviour. We asked how incidents

were analysed in order to identify themes and patterns. The manager, who had been in post for one month, confirmed this level of analysis had not been undertaken but they were planning introduce it.

We observed staff administering the morning medication in the dining room in a safe way. Medication was held in a secure trolley in a dedicated room. The room was locked when not in use. We observed that medication was administered to one person at a time. The member of staff stayed with each person to ensure they took their medication. They confirmed that medication training was provided for the staff who administered medication. We looked at the medication administration records (MAR). Besides some minor gaps, these were routinely completed. We noted that medication was sometimes not given but no reason was recorded as to why it was not given. A plan was in place for the medication people took only when they needed it (often referred to as PRN medication). No medication was used that required storage in a fridge. The management of medicines was audited monthly and we noted the last audit took place in November 2014.

Staff told us that two of the people living at the home were receiving medication covertly. This means medication is disguised in food or drink so the person is not aware they are receiving medication. This approach was taken as the person was refusing important medication for their health. We were advised that the GP had agreed this but there was no recorded evidence of a 'best interest' discussion having taken place to support the agreement. In addition, there was no record in place to suggest whether the person's family or representative had been involved in the decision making regarding covert medication. A care plan had not been developed to describe how staff should administer the medication in food and what they should do if the people did not wish to eat the food which contained the medication.

By not following good practice guidance regarding the use of covert medication was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We were informed of a serious allegation made by a person living at the home against a member of staff. This had been recorded internally within the home but had not been communicated to the manager therefore had not been reported as a safeguarding matter in accordance with local safeguarding procedures. Once we made the manager aware, they reported the matter to the Sefton adult safeguarding team. The care records informed us of physical altercations that had taken place between people living at the home. These should have been reported as safeguarding alerts but had not.

We spoke with staff about safeguarding. They had not taken into account that altercations between people living at home may need to be considered as a safeguarding matter. Furthermore, staff were unsure which organisation was responsible for managing adult safeguarding alerts; they thought it might be the Care Quality Commission (CQC). They told us a safeguarding policy was in place and they had access to it if needed. We checked the training records and it identified that 50% of the care and ancillary staff team had not completed adult safeguarding training. Some of the staff were new so were waiting to attend the training. However, at least five staff had been in post for longer than 12 months and had not undertaken safeguarding training.

By not making suitable arrangements to ensure people were safeguarded against the risk of abuse was a breach of Regulation 11(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the personnel records for two recently recruited members of staff. We could see that all recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff.

Arrangements were in place for regularly monitoring the safety of the environment and records were in place to support this. We noted that a health and safety audit was undertaken each month. The fire system was regularly checked. We asked staff whether each person living at the home had a personal emergency evacuation plan (often referred to as a PEEP) in place. Staff were not familiar with PEEPs and said they had not seen them in the home. The manager confirmed these had not been completed. The absence of PEEPs or similar means that people could be at risk from an unsafe or inappropriate evacuation from the building in the event of a fire.

We recommend that the service considers its arrangements for fire evacuation so the safety of people living at home is optimised.

One of the leather settees in the main lounge had a tear in the cushion and was wet through with an unpleasant

Inadequate

Is the service safe?

odour. We checked other seating and some of it was not very clean, in particular the cloth armchairs. We highlighted this to the provider and manager. The armchairs and settee cushion were removed that day and new seating was ordered. The provider confirmed there was a budget for replacing furniture and was uncertain why this had not been used by the previous manager of the home.

We had a look around the home including some bedrooms and observed that the environment was mainly clean and clutter free. We did note that a foot-operated clinical waste bin was not working correctly and we showed this to the manager who told us it would be replaced.

We spent time with the housekeeper who showed us their cleaning schedules and the checklist in each of the bedrooms to indicate cleaning had taken place. The housekeeper told us there us there insufficient time to undertake all the cleaning and other tasks required. We discussed this with the manager who confirmed that a housekeeper from one of the provider's other local homes had started to help out. The manager advised us that a second housekeeper had been appointed to start in January 2015.

We observed staff using disposable aprons and gloves when supporting people with their care needs.

The manager informed us that the lead for infection prevention and control (IPC) had recently left the service and another member of staff would take on this role once they had completed IPC training in January 2015. The training records informed us that the majority of the staff team were due to undertake IPC training on 7 January 2015.

We recommend that the service takes into account The Health and Social Care Act 2008 Code of on the prevention and control of infections (Appendix A) so that the spread of infection is minimised.

Inadequate

Is the service effective?

Our findings

Due to needs associated with memory loss people living at the home were unable to share with us there views. The two family members we spoke told us their relative's health care needs were being met. During the inspection people had visits from a GP and district nurses. We spoke with the GP who was satisfied that staff responded promptly to people's changing health care needs and followed through with instructions on how to manage individual health care needs.

From our conversations with staff and review of people's daily records it was clear people had regular input from health care professionals if they needed it, including the dentist, optician and chiropody. A form was in place to record all consultations with health or social care professionals. This was inconsistently completed and we highlighted this to the manager at the time of inspection. Staff had a good knowledge of each person's health care needs.

We spoke with a member of staff who had recently started working at the home. They said they received a thorough induction which gave them the confidence to work on their own with people. Staff told us they were up-to-date with their supervision and annual appraisal. Personnel records confirmed this. We looked at the training matrix (monitoring record) that outlined the training staff were required to complete. The provider confirmed the training had not been kept up-to-date. Some training had been organised to take place in January 2015, including dementia care, food hygiene and moving and handling training. Just 50% of the staff team had completed both fire training and first aid training and 59% had completed health and safety training.

Not providing staff with appropriate training was a breach of Regulation 23(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spent time in the dining room with people when they were having their breakfast and their lunch. Although people were unable to tell us how they made their dietary and food preferences known to staff, they told us they liked the food. Two people said they enjoyed the porridge at breakfast and said the puddings were nice. We observed that most people appeared to be enjoying their meals.

Large pictorial menus were displayed in the dining room. We highlighted to the chef that what people received for lunch did not reflect the menu and this could be confusing for them. The chef said this was an oversight as the menu was usually changed daily. The chef had a good understanding of people's dietary preferences. Some people were on blended diets and the chef explained that these meals were presented in an appetising way. People had a choice of meal and were asked the day before what they would like for the next day. The chef informed us that food was mostly prepared with fresh ingredients and puddings and cakes were homemade.

People had their meal in either the dining room or one of the lounges. We observed that of the 10 people who used the dining room, six people needed on-going prompting or assistance to eat their meal. Staff were under pressure to consistently provide this level of support as they had to leave the dining room to support other people having their lunch elsewhere in the building. Staff were also responding to a call bell that was activated frequently. We noticed that food went cold before it was served. For example, we intervened at breakfast to prevent cold toast being served to people. Fresh toast was made so it was warm when people received it. People were offered a choice of drink at each meal.

We observed people in the dining room spilling food on their clothing and the floor. Although napkins were available, people did not appear to know how to use them. We could see that some people needed plate guards (a device to prevent food falling off the plate). Staff provided these once we asked. Some people were unsure how to use their cutlery so resorted to picking up the food in their hands. It was clear they may have benefitted from using adapted cutlery. Other people were just pushing the food around the plate as if they did not what to do with it. Because of the inconsistent level of support people received and the spillage of food it was difficult to determine whether they had sufficient to eat and drink at each meal.

We noted from the care records that a person needed to be encouraged to have drinks frequently due to a re-occurring infection. We asked to see the documentation that staff used to record the amount of fluid the person was having. Staff did not think the person's fluid intake was being recorded.

Inadequate

Is the service effective?

By not adequately supporting and monitoring people with their food and drink meant this was a breach of Regulation 14(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We noted from the care records we looked at that people's weight was monitored on a regular basis to check for any fluctuation. Some people could not use a weighing scale so were not weighted. The manager agreed to look into alternative ways of determining people's weight, such as arm measurements.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Of the six care records we looked at two contained mental capacity assessments. However, they were generic in nature and did not clarify the decision that the person was being assessed to make.

One of the people living at the home was subject to a Deprivation of Liberty Safeguards (DoLS) standard authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. Documentation was in place to support this and it was evident that staff were in regular contact with other organisations and professionals involved in the authorisation. A GP visited the home during our inspection to carry out an assessment in order to renew the authorisation. We checked our records and there was no evidence that the provider had notified CQC, as required, of this DoLS authorisation.

Two people used bedrails. Although this item of safety equipment can be used to keep people safe when they are in bed, it can also be considered a form of restraint or restriction under the Mental Capacity Act. Where a person lacks capacity to consent to the use of bedrails, then the guidelines of the Mental Capacity Act should be followed. This means the equipment can be used if it is deemed to be in the person's best interests. We did not see in the care records that a best interest meeting or discussion had taken place about the use of bed rails for the people who used this equipment.

The staff we spoke with had a very limited understanding of the detail of the Mental Capacity Act and told us they had not received training in this area. They had a better knowledge of what DoLS meant but some staff did not think DoLS was part of the Mental Capacity Act. We discussed this with the manager who agreed to arrange training for the staff.

Not adhering to the principles of the Mental Capacity Act (2005) was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We had a look around the building to see how well it had been adapted to support the needs of people living with dementia. We observed that bedrooms, lounge areas and bathrooms were spacious, well-lit and clutter free. People could choose which lounge they wished to sit in and the conservatory provided access to a spacious and secure back garden. Age appropriate memorabilia wall art was located throughout the ground floor. Flooring was in a plain colour. Bedrooms were personalised to people's preference.

Colour contrasting had had not been used effectively. For example, the colours between walls, corridor handrails and doors were not contrasting so they stood out for people to find their way about more easily. Equally, bedroom doors were not painted in different colour so as to assist people in locating their bedroom. Not all signage was large enough or in a pictorial format to assist people with finding the room they may be looking for.

When reviewing the environment we recommend that the service takes into account national guidance regarding dementia friendly environments.

Requires Improvement

Is the service caring?

Our findings

Throughout the inspection we observed staff supporting people in a caring, respectful and dignified way. We heard staff explaining to people what was happening prior to providing care or support. Any personal care activities were carried out in private. Despite the pressure staff were under at meal times, they showed patience and understanding with people taking the time to listen to what people needed. Staff we spoke with demonstrated a warm and genuine regard for the people living there. Some staff had worked at the home for many years and said they liked their job because they enjoyed caring for the people.

Family members we spoke with said the staff were kind and caring and took time to support their relative with their needs. We noted that recent feedback questionnaires completed by families showed families were fully satisfied with the friendliness of the staff and atmosphere within the home. A family member said on the questionnaire, "When visiting, there is always a warm family feeling." Families and friends could visit the home at a time that they wished.

Staff confirmed that everyone living at the home had a family member to represent them so they did not need to use advocacy services.

Information about people's personal histories was not in any of the care records we looked at. This meant there was no information about the person's relationships, working life, hobbies and preferences in order for staff unfamiliar with the person to get to know or start a conversation with the person. When we asked, staff were uncertain about the personal history of a person who recently moved to the home. The manager advised us that each person should have had in their care file a 'Personal care handbook'. We looked at a blank handbook and noted it was comprehensive covering various aspects of a person's life. The manager advised us that these were usually sent to families to complete and they were then returned. Because the manager had just been in post for four weeks they were unable to explain why none of the six care files we looked at contained this document.

Although care plans were health rather than social care focused, we found that they were individualised to people's current needs. The care plans were worded in such a way that suggested people should be encouraged to make choices.

Most people had their own bedroom but there were two double bedrooms that people shared. Measures were in place to ensure the privacy and dignity of people sharing a bedroom. We asked how people or their family had consented to sharing a room with another person. Although we were informed families were satisfied with this arrangement, there was no paperwork in place to indicate they had agreed it. The manager agreed to clarify this with families and record their agreement.

The provider had recently installed closed-circuit television (CCTV) in communal areas of the home. CQC had received a number of calls suggesting that families were unhappy about it, it was a breach of people's privacy and the CCTV recordings were not stored securely. We reviewed the CCTV in line with CQC's guidance on the use of surveillance (December 2014) and determined it had been installed and was being used in line with best practice. We saw the consultation documentation sent to each person's nearest relative prior to installation and the responses received were in support of the CCTV. The provider confirmed that no families had objected to the CCTV. We could see that the CCTV was in communal areas and not in people's bedrooms, bathrooms or toilets. A policy had been developed that clearly outlined the security of the CCTV and who could access it. Only three people had access to the footage; the provider, the manager and the facilities organiser.

Requires Improvement

Is the service responsive?

Our findings

When we arrived for the inspection at 7.30 am two male care staff were on duty and they had worked through the night. We were informed that at least two nights each week there were male care staff only on waking night duty. We asked how the people living there, in particular the women, had agreed to being supported with their personal care by males. The staff said people had agreed to it and it was recorded in the care records. We looked at the care records for four women and two men. The plan for personal care included a reference to the person's preferred gender of staff. Some of these were not completed at all but for two women it clearly stated that they preferred to receive personal care from a female. There was no information in the care records to suggest that the principles of the Mental Capacity Act (2005) had been considered when people made a decision about their preferred gender of staff.

Not respecting the dignity and preferences of people was a breach of Regulation 17(1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We could see that care plans had been written and were reviewed by staff. There was no evidence from the care records to suggest that families were involved with developing and reviewing care plans. Staff advised us they contacted families if there was a change to their relative's needs. A family member who was visiting at the time of the inspection confirmed staff kept them informed of any changes. The care records we looked at did not reflect this level of communication with family. We noted that recent feedback questionnaires completed by families showed some families were not fully satisfied in their response to the question 'Do staff keep you updated regarding your care needs'.

People's preferences and preferred routines were documented in the care records. Each of the care records we looked at had a 'Night care summary' in place. It indicated people's needs at night and preferred times for getting up and going to bed. Staff told us there was no pressure to get people up in the morning and that people went to bed when it suited them. A 'kitchen notification' form was also in place for each person so that the chef and care staff of what people liked to eat and drink.

We could see that a programme of recreational activities was displayed on a notice board. We asked staff how activities were coordinated and provided. Staff told us the activity programme was not followed as they had to fit activities in when enough staff were available. They said sometimes they had time in the afternoon. We heard from staff that activities from external facilitators were also provided, including musicians and arm chair exercises. We looked at the 'Activity record' for December 2014 for all the people living at the home. There was very little activity recorded and some activities recorded were actually a personal care task. For example, we saw recorded as an activity that a person had enjoyed being shaved.

Because people's back ground and personal histories were not recorded, it was unclear how staff established each person's preferences for meaningful social and recreational activities. We noted that recent feedback questionnaires completed by families showed some families were not fully satisfied with the activities on offer. We concluded that activities were not person-centred or meaningful as they were not based on people's preferences and only took place based on the availability of staff time.

We recommend that the service takes into account Living well with dementia: A National Dementia Strategy when planning and providing social care and support for people living at the home.

We observed that a complaints procedure was available and displayed on a notice board. Families we spoke with were aware of how to complain. A family member told us they had complained about the food. We discussed this with the chef and manager and were reassured this had been promptly addressed through a meeting with the family. We were also informed of another recent complaint that had been addressed and resolved through a meeting with the family. We asked to see how complaints were monitored and logged so that the manager could identify any emerging themes. A complaints log was not available and the manager said they would put one in place.

Families could provide feedback about the care at the home by participating in an annual survey. The provider was in the process of seeking the views from families about the care provided at the home. Questionnaires had been sent out and seven had been returned. The provider was waiting to see if any more questionnaires were returned before carrying out an analysis.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in post as they had left the service at the beginning of November 2014. The registered manager from one of the provider's other locally registered care homes had been managing Hope Cottage for four weeks prior to our inspection. The provider informed us the manager would be applying to CQC to become registered manager of the home.

Over the last four weeks, the provider's operation support team (OST) had regularly been at the home and had conducted audits and checks to determine if improvements needed to be made to the service. The provider informed us that six mandatory audits were routinely undertaken each month by a member of the OST. They included a maintenance, catering, personnel, medication and infection control audit. We looked at a selection of these audits. We could see that action was taken if an audit identified concerns. For example, the infection control audit in November 2014 identified that staff needed training. We were provided with evidence that this had been booked for January 2015.

In addition, a member of the OST carried out a 'Service review' each month and the aim of this was to monitor the performance of the home manager each month. We could these audits had been routinely carried out each month.

The provider was open and transparent with us by acknowledging that the current monitoring and audit activity within the home had identified concerns with the service. The provider recognised that the service was not as good as it could be for the people living there. A development plan had been put in place to ensure improvements were made to the service. We had access to this plan and noted it covered all areas of care provision, staffing matters and accommodation. The plan lacked timeframes and the provider agreed to include these.

We highlighted some concerns we had with the layout of the environment at the end of the first day of the inspection and the provider had addressed these by the second day of the inspection. For example, the dining room had been moved to the back of the main lounge because it meant the kitchen was closer by and staff were better positioned to monitor and support people with their meals. In addition, the seating which was unclean and broken had been removed. This showed the provider's commitment to improving the service in a timely way.

Other changes that had been introduced or were due to be made shortly, included a monthly award for the employee of the month, the re-introduction of a keyworker system and the recruitment of activity organiser. Also included on the development plan was the aim to encourage families to complete the 'Personal care handbook' and a complete audit of the environmental and equipment needs of the service.

The majority of the staff we spoke with were pleased with the very recent changes. Some staff said the service was starting to become more structured which they liked. They said two staff meetings had taken place in the last month to inform them of planned changes to improve the service. In particular, staff were delighted that the dining room had been moved and were keen for the key worker system to be brought back. They said they were hopeful the staffing levels would be improved. One of the staff said to us, "In the last two weeks I have seen the home getting better."

All the staff we spoke with were aware of what whistle blowing meant and said a policy was in place at the home. They said they would not hesitate to whistle blow if they were concerned about how people living there were treated.

At the time of the inspection there was no process in place to involve families in the development of the home. The manager said they had planned to organise a meeting for relatives. In the last month the manager had coordinated two staff meetings so that staff were involved and received communication about changes to the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Staffing levels were inadequate to ensure the safety at all times of people living at the home. Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with the unsafe management of medication because covert medication was not administered safely and in accordance with good practice guidance. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People were not safeguarded against the risk of abuse. Regulation 11(1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff People's health and welfare needs could not be ensured because staff training was not up-to-date. Regulation 23(a).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not protected against the risk of inadequate nutrition and hydration because adequate support was not available at mealtimes to ensure people had sufficient to eat and drink. Regulation 14(1)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People were not supported to give valid consent to care because the principles of the Mental Capacity Act (2005) had not been adhered to. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The privacy and dignity of people was not respected because they were not receiving care from their preferred gender of staff. Regulation 17(1)(a)(2)(a)