Serendib Limited

The Birches

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 21 November 2017 and was unannounced.

The Birches is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Birches accommodates up to 19 people in one adapted building. At the time of our inspection there were 15 people living at the home.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This is a first rating inspection since the home was registered by the new provider in April 2017.

We found there was a lack of oversight by the provider's representative to check quality monitoring had been carried out effectively. The quality monitoring systems included reviews of people's care plans, food temperature checks and checks on medicines management. These checks and systems were not reviewed by the nominated individual to ensure people received a quality of service. Accidents, incidents and falls were recorded but not analysed to prevent further incidents from happening. Improvements were required in assessing risks to people and how staffing levels were determined to ensure safe levels of care were maintained to a standard that supported people's health and welfare.

The nominated individual did not have effective systems in place to assess, monitor and improve the quality of care. There was no system in place by the nominated individual to supervise or oversee the staff and how they ensured people were safe in the home.

Health and safety checks were not regularly completed to ensure risks to people's safety were minimised. We identified some health and safety issues to the nominated individual on the day of our inspection visit where we had immediate concerns to people's safety.
The administration of medicines was not consistently secure and written instructions to ensure medicines were given accurately were not always in place.

Care plans provided information for staff that identified people's support needs and associated risks. However, care plans and risk assessments required information to be updated to ensure staff provided consistent support that met people's changing needs.

There were enough staff on duty to respond to people's health needs and to keep people safe and protected from risk. However there was no dependency tool in place to establish safe staffing levels.
Staff recruitment procedures was adequate which ensured people were cared for by staff who had been assessed as safe to work with people.

People were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's capacity had been assessed but further improvements were required to ensure these were updated and reflected people's capacity. One person had a DoLS in place at the time of our inspection.

Staff knew how to keep people safe from the risk of abuse. People told us they felt safe living at The Birches and visiting relatives felt their family members were safe and protected from abuse.

People felt cared for by a caring and compassionate staff group who understood people's needs, abilities and allergies. Staff told us they had been trained, but we could not identify when this had taken place, as there was no record of training updates in place. We asked the nominated individual for a copy of this but it was not forwarded following the inspection.

People said staff provided the care they needed. Care was planned to meet people's individual needs and abilities. Care plans were not regularly reviewed and information required to be updated to ensure staff had the correct documentary information to support people as their needs changed.

People were provided with meals that met their cultural and dietary needs. Health professional advice was sought for all those at risk of malnutrition and dehydration. Staff ensured people obtained advice and support from health professionals to maintain and improve their health.

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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were at risk from harm as staff did not ensure all areas of medication administration was safe. The administration of medicines was not consistently secure and written instructions to ensure medicines were given accurately were not always in place.

Infection control procedures were not detailed, and people were placed at risk from the potential for transfer of infection from a poor environment.

Policies and procedures had not been updated to include information for staff to ensure policies were followed consistently. Periodic safety tests of the environment were not recorded by staff, though some were undertaken by external experts. Safety certificates confirming work had been done to a suitable standard were not available.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff told us they had completed essential training to meet people's needs but there was no documentary evidence to confirm that training was regularly updated to ensure staff were in receipt of the latest guidance on best practice. Where there was conflicting information about people's capacity to make specific decisions, mental capacity assessments had been completed. However we were unsure if these were still valid as they had not been updated recently.

People were supported to maintain their health and referred to external healthcare professionals when a need was identified.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us when staff spent time with them, they were caring and understanding though this was limited due to staff availability, and provided few chances for social stimulation.

Staff provided care in a kind and compassionate manner, and respected people's privacy and dignity. Staff assistance recognised people's abilities and helped them to remain independent. Care plan reviews have taken place and when appropriate involved people's relatives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their families were not always involved in planning or reviewing how they were cared for and supported. Staff understood people's preferences, likes and dislikes. There was no planned individual activities and pastimes to ensure people were stimulated.

Is the service well-led?

Inadequate

The service was not well led.

Some quality assurance systems were in place, however there was no oversight or governance by the nominated individual to ensure people' safety was not compromised. Records of some tests were completed by staff, however these were not overseen by the nominated individual to ensure that shortfalls were identified and resolved and did not endanger the safety of those in the home.

The Birches

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 21 November 2017, and was unannounced. The inspection team consisted of one inspector, a specialist adviser and 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. A specialist adviser is a qualified social or healthcare professional. Both our specialist advisor and our expert by experience's area of expertise was in the care of the elderly.

Before our inspection visit, we reviewed the information we held about the home and information from the local authority commissioners.

We spent time observing the care being provided throughout the home. 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. We spoke with four people using the service, four visiting relatives, the provider, four care staff, and cook.

We looked at the notifications from the provider; a notification is information about important events which the service is required to send us by law.

We looked at records relating to all aspects of the service including care and staffing, as well as policies and procedures. We also looked in detail at four people's care records and the recruitment files of three staff.

We observed the support offered to people in communal areas and looked at the care records for three of the people who lived in the service. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

We contacted commissioners for health and social care, responsible for funding some of the people that

lived at the home and asked them for their views about the service. They told us they had some concerns about how the home was being managed.

Requires Improvement

Is the service safe?

Our findings

People told us they received their medicines regularly. One person told us, "[named staff] stays around to make sure you take your medicine."

We looked in detail at the medicines system, staff had not ensured people's safety, where a person had been prescribed a medicine that they had an allergy to. We mentioned this to staff who immediately rang the doctor for information on what to do about the error. We looked at the Medication Administration Record (MAR) chart and saw there was some information on allergies but this did not cover all of those the person was allergic to. We looked at the person's care plan, which had a detailed risk assessment which listed all the person's allergies. That meant the person was placed at serious risk from a medicine being wrongly administered.

We spoke with the pharmacist regarding the allergy information on the MAR chart. They were unaware of the entire list of the person's allergy information, as this had not been communicated by the staff.

The policy for safe storage and administration of medicines had not been updated since October 2015. The current policy did not include any information on how the systems used were audited to identify any medicines issues. There was no procedure for staff to follow to enable them to safely order, store, administer and dispose of medicines. The inclusion of medicines procedure to accompany the policy would have ensured staff were informed of the administration process.

There was no evidence the storage temperatures of medicines were recorded regularly. Temperature records are required to ensure that the medicines remained active and were safe to use. We spoke with the nominated individual who said he would ensure staff commenced this record of temperatures.

Staff told us they had received training to ensure people's medicines were administered appropriately. However we could not check this as there was no list of training events staff had undertaken. We spoke with the nominated individual about how staff were trained and monitored to ensure they administered medicines safely. The nominated individual said training had been undertaken, but could not provide dates; he also confirmed he did not undertake any staff observations to ensure staff adhered to the safe principles of medicines administration.

The lack of insight and absence of any detailed and thorough audits by staff or the nominated individual has contributed to the unsafe practices we observed at inspection.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Medicines.

Routine tests of the fire and evacuation system, water sampling, gas, hoists and stair lift had been undertaken by qualified companies external to the home. However certificates to confirm these systems were safe were not available as there were no copies available in the home. The nominated individual told

us all the work was done, and the systems were safe. We passed this information to the local authority Health and Safety representative, who made a follow up visit to ensure the premises were safe and people were cared for safely. That meant the nominated individual was not exercising his duty of care over the people living in the home or staff group.

We were unable to locate the last report from the environmental health officer, but staff told us the outcome was level 2 (out of a good rating of 5). There had been no kitchen cleaning audit that had been undertaken by the staff and no governance audit by the nominated individual. That meant there was no plan of improvements to enable the home to regain a food safe rating which protected people in the home.

On a tour of the home we saw that a bathroom was unusable and was being refurbished. There was cleaning equipment stored in a corner of the room, but the door was not locked to stop anyone accessing the room, and falling over the trip hazard. There had been a number of improvements where bedrooms had en suite toilets had been added and some areas were newly decorated. However there was no recorded plan of refurbishment, so we could not be sure areas that directly affected peoples' safety were to be replaced. For example there was a carpet in a corridor which was threadbare and where it was joined the edge had started to fray. This had the potential to place someone at risk of a trip or fall. In a toilet there were bricks supporting new pipework which staff said were to be boxed in. In some corridors' there was wallpaper which had been torn off, and in other areas it was peeling off the walls. We asked the nominated individual about the refurbishment programme who said he would improve areas when he could, but did not have a written plan. That meant there was no way to prioritise work and ensure people were safe.
The lack of audits performed by staff or the nominated individual has attributed to the poor environment and unsafe practices we found on inspection.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe environment.

The laundry floor had been sealed but this had now been perforated, and did not ensure it could be cleaned or disinfected properly, to reduce the potential for cross infection or cross contamination in the home. The plinth that the washing machine is placed on was rusty which did not allow adequate cleaning and disinfection. We observed there was inadequate separation between clean and soiled linen, which again placed people at risk of cross infection or cross contamination in the home. Some areas of the home did not have pedal operated bins to ensure infection controls were upheld.

We asked staff about access to the policy and procedure on infection control though they were aware they were situated in the office. However these were not personalised to the home, and did not inform staff the correct procedures to enable all areas of the home to be kept clean and hygienic.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Infection control

People told us they felt safe, one person said, "I feel safe here and I like to leave my door unlocked so it's easy for the girls [staff] to come in to my room."

Care staff were confident that people were safe from harm and said they would report any concerns of abuse to a senior member of staff. Staff were aware of how to contact external agencies such as the local authority safeguarding or CQC and said they would do so if they felt their concerns were not dealt with. Staff confirmed they had been provided with the relevant training and guidance to ensure people were safe. However we could not confirm this due to the lack of training records.

Staff we spoke with had a clear understanding of the different kinds of potential abuse, and most told us they had received training on how to protect people from abuse or harm. They were aware of their role and responsibilities in relation to protecting people and what action they would take if they suspected abuse had happened within the home.

One member of staff said, "If I thought someone was being abused, I would call the safeguarding team or CQC. All of the staff we spoke with were aware of whistle blowing, and said they had not seen anything that required reporting or gave them cause for concern.

People's relatives told us they had reservations about the staffing numbers in the home. One family member said, "[They are] a bit short [staffed] at times." A second family added, "The girls [staff] are always running about, they could do with more [staff]. They went onto explain when they visited there was not always staff in the lounge to assist people and ensure their safety.

Staff told us there was not always enough staff to care safely for the people in the home, though staffing numbers had been increased recently. The nominated individual told us that care staffing levels to support 15 people had been increased recently and there was now a senior carer and three care staff in the mornings, afternoon and evening and two waking care staff at night. A cook and housekeeper were also included on the rota.

Care plan assessments to ensure that staffing numbers were sufficient to meet people's individual needs and ensure people were safe had not been updated since June 2017. We could not be assured the abilities of people had been assessed properly and could not be assured that the staffing numbers ensured people were safe. There were currently no processes in place, for making sure that staffing levels were adequate, and the right mix of staff with the required skills, competencies, qualifications, experience and knowledge, were available to meet people's individual needs.

We looked at the people's personal evacuation plans (PEEPs). These inform staff how to safely assist people to leave the premises in an emergency. Copies of the PEEPs were kept on people's files so were not readily available in an emergency. We saw these had not been reviewed recently, but reflected people's mobility needs. Staff we spoke with were aware of the location of the PEEPs and fire and emergency evacuation equipment. However staff confirmed they had not taken part in a recent fire drill and the records of the drills did not have an accurate record of what staff had taken part. We spoke with the nominated individual who assured us they would organise fire drills to bring the entire staff group up to date with the evacuation procedures, and records to match. That meant there was a potential that they were not fully aware what action to take in the event of such an emergency.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. They told us they received an induction and on-going training for their specific job role, however we could not confirm the training provided as we had no access to the training matrix.

Staff told us they had completed training courses on chemicals and control of substances hazardous to health (COSHH). We found that cleaning chemicals were locked away. COSHH data sheets were in place to inform staff the correct procedure in the event of an accident with these chemicals.

As there was no registered manager and inconsistent visiting by the nominated individual, there was no review of incidents or documents to ensure any short falls were addressed. Nor was there any analysis from these incidents to ensure information gathered from lessons learnt, was used to inform staff development and practice to ensure a safe environment.

Requires Improvement

Is the service effective?

Our findings

People told us they felt staff were trained to do a good job. We could not ascertain if staff had the up to date training required to provide safe effective care to people. Staff told us they had received training to do their job. We tried to look at the staff training matrix but we were unable to access the document on the day. We asked the nominated individual to forward this following the inspection but they did not do so. We asked the provider to send us a copy of the training matrix, but again he did not do so. That meant we could not be assured the needs of people were met consistently by a staff group who had the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours.

Senior staff told us they were not supervised by the provider. Supervision can be used for staff development and uses an exchange of information to drive change and improvements in the home.

We asked the nominated individual why in the absence of a registered manager they had not arranged supervision with the senior staff. They told us, "That is the weak point; I leave that to the manager." They added that senior staff were expected to supervise the care and other staff in the home. One member of senior staff told us, "I can't supervise people on areas I am not qualified in." That meant that staff were not supervised or developed to ensure any specialised training was recognised and staff worked effectively in the home.

We asked the nominated individual for a policy and procedure to see what the provider expected that supervision would include. The nominated individual was unable to find a policy or procedure.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We spoke with staff who confirmed they had undertaken MCA training. We could not be sure all the staff fully understood the principles of the Act, as some were unsure of what they could legally prevent people doing to ensure their safety. Staff were able to explain that choices were given to people prior to a task being undertaken. Staff were aware that people were presumed to have capacity to make decisions unless proven otherwise. Staff told us, where people lacked capacity they still offered choices. Throughout the inspection we heard staff explaining to people and seeking their consent before they commenced a task. One member of staff said, "It's about letting people know what we need to do, and getting their agreement."

We saw that people had consented to care by signing forms for areas such as personal care, medicines, sharing information and taking photographs. These had not been updated recently and it was not clear if people still had capacity to continue their agreement.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, one application had been approved by the local authority to make sure people's freedoms were not unnecessarily restricted.

People's needs were discussed at handover between the change of shifts, however this was not recorded or used to inform or update people's care plans or risk assessments. That meant the information exchanged between people was not recorded so staff who were not on shift could not learn from and update their practice due to the absence of updated information.

People and their relatives we spoke with were happy with the quality of food. One person told us that the portions were adequate and they could have seconds whenever they liked. They said, "I had two bowls of soup yesterday, it was lovely." Another person said, "We get three lovely meals a day."

We observed what support people were offered during their lunchtime meal. We overheard one member of staff who asked one person which type of drink they required with their lunch, offering a choice of three. There was one main meal on offer at lunch time. We saw the cook produced alternative choices for people that preferred an alternative. The cook said it was a small home and staff knew people's preferences. We saw a list of likes, dislikes and allergies in the kitchen, the cook told us all the staff knew where it was and other staff confirmed this and were able to tell us about people's food allergies. People told us and we saw that they received regular hot and cold drinks throughout the day.

We found people's weight was measured and recorded. Where people were unable to stand to be weighed the staff had obtained information from the district nurse, which enabled people's weight loss or gain to be monitored. People had been referred to their GP and other medical professionals such as dieticians and speech and language therapists, where concerns about people's food or fluid intake had been identified.

Staff were able to tell us about people that required changes to their drinks or diet. Information in care plans detailed people's dietary needs and people were provided with meals that met their cultural and dietary needs. Some people were referred to healthcare professionals to ensure the appropriate dietary information and choices. For example in one file was saw the person required thickened fluids, to prevent them from choking. That meant staff had the appropriate information about people's dietary requirements.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were caring and responsive. One person said, "The carers are very good, I'm very content." A second person said, "I'm happy living here, the girls know I'm happy and they couldn't look after me better [named staff] is very good."

Visiting relatives we spoke with commented, "The girls [staff] are excellent, under pressure but very caring." A second said, "I'm happy with [named person] care."

We observed staff interactions with people throughout the inspection which showed that staff were caring, helpful and people were treated respectfully. Staff demonstrated patience when they supported people to allow them to maintain a pace that was comfortable for them. We saw the staff member walk with them, encouraged them and gave simple instruction to enable their unobstructed progress to their chair. We observed a carer assisting a person to sit in a chair in the day area after lunch. This was carried out in a gentle and encouraging way with a focus on compassion, comfort and warmth. We heard the staff ask, "Do you want a blanket over you?" That demonstrated a caring and compassionate attitude, whilst recognising the person's ability to maintain the independence.
However where staff were able to demonstrate a caring attitude whilst caring for people they were unable to spend meaningful quality time with them. That would have allowed people a greater interaction to build relationships and staff to provide further social stimulation.

Records showed that family members had been involved in care plan reviews, however these had taken place some time ago and care plans needed to be reviewed to ensure that information was up to date. We saw there was information in care plans to ensure people were referred to by their preferred name. People's individual religious beliefs were recognised and respected and the current activity with their religion was also noted.

We saw that there was information regarding independent advocates available at the service. An advocate can assist people who have difficulty in making their own, informed, independent choices about decisions that affect their lives. We discussed advocacy with the nominated individual who was not aware of anyone using this service recently.

Throughout our visit we saw that people were able to make choices about how and where they spent their time. We observed staff knocked on people's bedroom doors before entering which meant staff recognised and respected people's privacy and dignity. One person told us that when she went to spend an afternoon out, she would let a carer know and they would arrange a mobility adapted taxi to pick her up. Visitors told us that they were made to feel welcome by the staff.

We observed a member of care staff who assisted a person using the service, prior to eating their lunch. The member of staff ensured the person's clothes were appropriately covered before providing their meal, and asked if it was ok for the cover to be removed following the meal. That ensured the person's wishes were respected.

Staff we spoke with told us they encouraged as many people as possible to maintain their independence as long as they were safe to do so. Throughout our visit, we saw staff encouraged people to make their own decisions and prompted them to move around independently. For example we saw where staff prompted people to walk to the dining room and remained at a safe distance to give encouragement and friendly instruction.

We asked people if their privacy and dignity was recognised, and how staff enabled this, one person said, "They [the staff] always knock."

An example where staff respected people's dignity was where we saw a person being helped to transfer from a wheelchair into their lounge chair. Staff ensured there was a privacy blanket in place at all times which ensured the person's dignity. We heard staff gave clear instructions to the person and allowed them to dictate the pace. We observed care staff interacted well with people, and engage them in conversation.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people in the home who told us staff provided safe care that meets their needs. Relatives we spoke with told us the staff seemed to know what care and attention people required and knew their individual needs.

We spoke with three staff who demonstrated they were aware of people's individual needs, and were aware of people's, preferences and allergies. For example one person was allergic to certain food and drinks, when we asked the member of staff they demonstrated by informing us of the specific food and drinks the person was unable to have.

People and their relatives told us they received the care and support they needed to maintain their daily lives. One person and a visiting family member confirmed they were involved in decisions about their or their relative's care. We saw that some people or their relatives had signed their care plans and risk assessments to confirm their agreement with the care being offered. Another person explained they required assistance to get dressed in a morning. They told us they had the option and got up when they chose, at a variety of times. They added they rang the call bell for staff assistance which came promptly and indicated they were never hurried whilst being assisted.

Care plans and risk assessments had not been updated since June 2017 and we saw that these did not reflect people's current needs. For example we looked at the conditions placed by the local authority on a person whose liberty was restricted by a DoLS. These specified that that the person should be supported to go out for regular walks, have meaningful activities and be provided with written communication to aid choice, which were all reflected in their care plan. The person's ability to undertake trips out had diminished due to a downturn in their health, but this had not been reflected in changes to their care plan. We saw staff had a range of pictures to enable communication with the person, but no evidence of individual meaningful activities. That meant care plans were not detailed with people's individual needs.

Some people told us they were able to follow their own hobbies and interests. One person told us they loved gardening and in the spring and summer months that they liked to get out as often as possible to help tend the garden. A second person told us that they liked to knit most days, another that they liked to read and that books were readily available within the home. Other people mentioned that pastimes also included singers, painting and games.

However we could not find a planned activities programme for people. Staff told us that since the activities person was not at work they struggled to offer any activities to people on a regular basis. We did not see staff engaging in any activities on the day we inspected. One relative felt there were not many opportunities for people to get involved in activities. A second relative commented that when activities were undertaken this was usually in the lounge and there wasn't enough room and suggested that staff should consider using the dining room.

We spoke with the nominated individual about the provision of activities in the home. They said they were

unaware there was no regular programme of activities offered to people, and agreed until the return of the activities staff, staff would be allocated specific time to undertake activities. Activities are important to ensure people are provided with person centred events and are stimulated to reduce the effect of social isolation. We found people were offered support that met their cultural needs. People told us there were religious services that met the different denominations within the home.

We recommend that a suitable programme of activities, based on people's interests and choices, is provided at the service.

We asked the nominated individual about how he had introduced the accessible communications standards to the staff group. These allow staff to recognise, assess and record the communication needs of people who have been affected with a hearing and /or sight loss, or communication debility caused by a life changing event. The nominated individual was not aware of, nor had instructed the staff in the five steps within the assessment process. That meant people's accessible communications needs were not part of a holistic assessment process which should enable individual and responsive communication between people in the home and entire staff group. We did however see that one person was using pictorial cards to communicate on days when their abilities were lessened.

When we spoke with people they told us they were happy and content. One relative commented, "I have no complaints, if I did I would speak with [named staff]."

None of the people or relatives we spoke with had made a complaint but most said they would speak to one of the senior carers if there was something they were not happy with.

The provider had systems in place to record complaints. People we spoke with said they knew how to make a complaint. Records showed the service had received one written complaint in the last 12 months, which had been investigated, and a written explanation sent to the complainant. Feedback about the complaint was provided for staff though this was in a verbal form, and was not part of any planned staff meeting or individual supervision. We looked at the complaints policy and procedure, which included details of the local authority, which are the appropriate body to investigate complaints.

Inadequate

Is the service well-led?

Our findings

The provider had appointed a person who was responsible for control of the day to day running of the home, who had been in sole charge since the resignation of the registered manager in August 2017. We spoke with the nominated individual about the input and governance he had throughout his time at the home. The nominated individual stated he visited the home most days and purchased all the food and cleaning items. We asked about the governance he undertook and asked for evidence this had been completed. The nominated individual stated he had not undertaken any governance, nor ensured the staff had undertaken the range of tests required to ensure the premises were safe for people to live and work in. This demonstrated the nominated individual does not have the skills and experience to ensure the safety of people in the home.

We found few health and safety checks had been completed since June 2017, which meant we could not be assured the home was a safe environment for people to live and work in. We asked to see the policy and procedure on how staff should undertake these tests. The nominated individual could not find any guidance, and told us he did not supervise the staff to ensure the checks were done.

Staff said they reported maintenance issues and these were followed up by the nominated individual, however there was no written record of these or what action was taken. That meant there was no record of when items were first identified for repair, so we could track the progress of any issue and ensure these were done in a timely manner.

There was a lack of regular and consistent health and safety checks performed by staff to ensure a safe environment. Temperature checks of cooked food, fridge and freezers were all recorded, but there was no oversight of those by the nominated individual. We found there had been no checks performed on the fire and evacuation system, water sampling or hot water temperatures which could potentially leave people at risk of harm

We asked to see the latest safety certificates to ensure the hoists and stair lift had been serviced and were safe to use. The nominated individual could not produce the certificates at the time and we provided a list of those and other test certificates we required at the end of the inspection. When we received the electrical test certificate we were aware there was outstanding work that was required to ensure the safety of those in the home. This included work that was classified as 'urgent' and posed a risk to people. This work was completed however there is still electrical work that needs to be undertaken to ensure people's safety. Until we prompted the nominated individual this work had not been undertaken, a full ten months after the electrician made the nominated individual aware of the fault. This does not demonstrate an effective and responsible person or a well-led service.

None of the other test results and safety certificates were sent and we had to remind the nominated individual to send these again. Due to the failure of the nominated individual to ensure people's safety, we reported our safety concerns to the local authority.

We spoke with the nominated individual about the systems used to assess monitor and improve the quality of services provided in the home.

The policies and procedures had been purchased from a company and covered a number of areas which related to the home. However the nominated individual had not ensured these had been personalised to the home, and did not provide staff with any guidance or personalised instruction about how to keep people safe or operate processes in the home. We found the nominated individual had little personal experience or knowledge of running a residential care home. Nor had he arranged any training to ensure he obtained the skills and knowledge or accessed information from experts or other agencies about best practice and changes to ensure people were safe and cared for appropriately.

We attempted to look at staff training but the document used by the home to record the training people had undertaken could not be sourced on the day. We asked for this to be sent, and even after we prompted the nominated individual these were not forwarded. We cannot be sure the staff training is up to date, or that there is a clear staff development plan to ensure staff training was up to date. This again demonstrated there was a lack of oversight by the nominated individual.

Staff confirmed there was no formal system of supervision by the nominated individual. That meant that senior staff were working without any direct guidance. A supervision policy has still to be formulated and put in place, to indicate how often supervision should take place and the structure of these sessions.

The nominated individual lacked insight into the safe and effective running of the home, which impacted on the quality and safety of the service offered. Quality assurance and governance were either non-existent or where evidenced not used effectively to drive continuous improvement in the home.

This is a breach of Regulation 17(a) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the nominated individual about the provider's vision and values. They said, "My vision is to have a good team to work together." They went on to explain he knew of nothing in writing about the vision and values, but there were regular staff meetings where this was discussed. The nominated individual explained since the home had been without a registered manager there had been two staff meetings, the latest of which he had not attended. When we spoke with staff they were unaware of the provider's vision and values.
The nominated individual told us he had not issued any questionnaires or held any meetings for people who used using the service or their relatives. However he did say there was a suggestions box people could use if they had any improvements that he could implement. These could be used to gather information about the home, and allowed people to suggest improvements.

There was no clear strategy from the nominated individual to deliver consistent high quality care and support to people. The nominated individual had limited knowledge or training that would allow them to direct staff to provide good outcomes for people.

There was limited evidence that staff worked in partnership with other agencies where required. Information from professionals was sought on a case by case basis, where specialist knowledge was required. For example staff were in receipt of knowledge and understanding of people's dietary needs and specialised knowledge around the care and treatment of people.