Snow Peak Limited

Pensby Hall Residential Home

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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This was an unannounced inspection carried out on 17 and 20 August 2015. Pensby Hall Residential Home provides personal care and accommodation for up to 30 older adults. Nursing care is not provided.

The home is a detached house situated within walking distance of local shops and public transport. Accommodation consists of 30 single bedrooms, four of which have en-suite facilities. A passenger lift enables access to all floors for people with mobility problems. On the ground floor, there is a communal open plan lounge/ dining room for people to use and a conservatory.

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

Summary of findings

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.'

At the time of our visit, the provider was acting as the manager at the home but was not registered. This meant that the provider had not been verified by The Care Quality Commission (CQC) as a 'fit' person. The provider was requested to submit a registered manager application by CQC but failed to do so.

People we spoke with told us they felt safe at the home. They had no worries or concerns. People's relatives and friends also told us they felt people were safe. During our visit, however we identified serious concerns with the safety of the service.

We found breaches in relation to Regulations 9, 10, 11, 12, 13, 15, 17, 18 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.

We found a number of safeguarding incidents had not been documented or appropriately reported. This meant that there was no evidence these incidents were properly investigated and responded to by the provider. There was no evidence that staff members had received safeguarding training as no training records had been maintained. This meant there was risk staff would not know what to do in the event of an allegation of abuse being made.

People's dependency needs had not been considered in the way that staffing levels were determined. The provider did not have a clear understanding of people's needs and the care they required. We found that staffing levels, and the deployment of staff during the day, required improvement.

Staff were recruited safely but there was insufficient evidence that staff had received a proper induction or suitable training to do their job role effectively. Some staff had been supervised but the competency of staff had not been assessed to identify and addressed any training needs they had. This meant there was a risk that staff lacked the required skills and knowledge to care for people safely.

The premises was unsafe, unclean and poorly maintained. Some bedrooms were cluttered with trailing electrical wires which posed a trip hazard. There were unsafe windows in a number of bedrooms, some carpets were stained and worn and parts of the home were malodorous. No environmental audits were undertaken to ensure the environment was safe and suitable for purpose. Smoking took place inside the home without adequate safety provisions being made and the provider did not have an up to date fire risk assessment or adequate emergency evacuations procedures in place to keep people safe.

Infection control standards at the home were poor and standards were not monitored and managed. The provider had scored poorly at a recent NHS infection control audit and had not taken appropriate action in a timely manner. This placed people at risk from infection.

We observed a medication round and saw that the way medication was administered was safe. Records relating to people's medicines matched what had been administered. Medicines were not always stored safely and there was no evidence that staff administering medication were trained and competent to do so.

We reviewed three care records. Care plans were brief and poorly written. They did not accurately reflect people's needs and wishes and were not person centred. Dementia care planning was poor and support for people's behavioural and emotional needs inadequate. The majority of risk assessments were poor and failed to provide staff with any guidance on how to manage people's risks and care for them safely. Where risk management actions had been identified, they had not always been carried out to ensure people received the support they needed to keep them safe. This placed people at risk of harm.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had not been adhered to in the home. The provider told us the majority of people at the home lacked capacity and that a number of Deprivation of Liberty Safeguard (DoLS) applications had been submitted to the Local Authority in relation to people's care. People's capacity to make their own specific decisions had not been assessed and there

Summary of findings

was no evidence that any best interest meetings had taken place or least restrictive options explored. There was no evidence that staff were trained to support people with these needs.

People we spoke with said they had no complaints. The provider told us two complaints had been received over the last 12 months but no complaint records were available to verify this.

People had access to sufficient quantities of nutritious food and drink and were pleased with the choices and standard of the food on offer. They said they were happy with their care and everyone we spoke with gave positive feedback about the staff and the way in which they were looked after. We observed that staff treated people kindly and supported them at their own pace. It was clear from our observations that staff knew people well and people were comfortable and at ease with staff.

We found that some staff were not always observant to people's general welfare and dignity needs, for example, two people were served meals that they could not reach comfortably and some people's continence needs were not addressed in a way that protected people's right to privacy. People's independence was not always sufficiently promoted and some people had not received a bath or shower for significant periods of time.

The service was not well led. There were no adequate systems in place to ensure the service was safe, effective, caring, responsive and well led. There were no building audits, infection control audits, care plan audits or adequate accident and incident monitoring in place to ensure people were safe and well cared for. All the policies and procedures we looked at were out of date and there was no evidence they were followed. At the end of our visit, we discussed the serious concerns we had about the service with the provider and deputy manager. The provider was unable to provide a satisfactory explanation as to why the issues we identified during our inspection had not been picked up and addressed.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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

Safeguarding incidents were not appropriately reported and the majority lacked any evidence that incidents were investigated and acted upon where necessary.

People's individual risks in the planning and delivery of care were not properly assessed or managed.

Staff were recruited safely but staffing levels and the way staff were deployed 'on the ground' was unsatisfactory..

Some medicines were stored in people's rooms without the necessary checks to ensure they were safe to do so. There was no evidence that staff administering medication were trained or were competent to do so.

Is the service effective?

Inadequate

The service was not effective.

Where people had mental health needs that could potentially impact on their capacity, the principles of the Mental Capacity Act 2005 and DoLs legislation had not been followed

There was no evidence that staff were suitably trained or that their competency had been assessed. Some staff had not received supervision.

People were given enough to eat and drink and a choice of suitable nutritious foods to meet their dietary needs.

Is the service caring?

Requires improvement

The service was not consistently caring.

Everyone we spoke with, spoke highly of the staff at the home and the care they received. Staff were observed to be kind and patient with the people they supported.

Staff we spoke with were familiar with people's needs and spoke warmly about the people they cared for.

Staff were not always observant to people's welfare and dignity needs and people's dignity, privacy and independence were not always promoted.

Is the service responsive?

Inadequate

The service was not responsive

People's needs were individually assessed but care plans were poor, not person centred and were contradictory about people's needs and risks.

Summary of findings

Appropriate care planning and support for people's emotional well being and mental health had not been undertaken and people's mobility needs were not always supported.

A range of social activities was provided and the activities co-ordinator took time to build positive relationships with people

People we spoke with had no complaints about the care they received. The provider's complaint policy lacked important contact details for who people could complain to.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of effective monitoring systems in place to check the service was safe and of a good standard.

Appropriate actions and referrals to external bodies had not always been made, or actions followed up in a timely manner.

Policies and procedures were out ot date and were not followed.

People had little opportunity to have an input into the service and expres stheir views.

Pensby Hall Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 20 August 2015. The first day of inspection was unannounced. The inspection was carried out by two Adult Social Care (ASC) inspectors and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also spoke with the Local Authority.

At this inspection we spoke with five people who lived at the home, six relatives and friends, the provider, the deputy manager, two care staff, two catering staff and a GP. We looked at a variety of records including six care records, seven staff records, a range of policies and procedures, medication administration records and other paperwork relating to the quality of the service.

We looked at the communal areas that people shared in the home and did a tour of the home. We observed staff practice throughout of our visits and used the Short Observation Framework Tool (SOFI) during the lunchtime period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Inadequate

Is the service safe?

Our findings

We spoke with five people who lived at the home and six of their relatives and friends. People said they felt safe living at the home and spoke positively about the staff. People's comments included "Absolutely safe, a lot safer than home"; "Like the routine. I'm absolutely safe, nothing scares or frightens me now" and "Staff treat me well".

People's relatives and friends told us they thought people were safe. Comments included "They (the person) are 100% safe here"; "They're safe in the home" and "They're very safe. Definitely well treated, they are very happy here".

The provider had more than one policy in place for identifying and reporting potential safeguarding incidents. Although similar, it was unclear which policy was the most up to date and to be followed by staff in the event of an allegation of abuse being made.

Staff we spoke with told us they had received training in safeguarding. We asked the provider for evidence of this. They were unable to tell us or produce any training records to show which staff members had safeguarding training or when this had taken place. This meant there was no evidence that staff members were trained in how to identify, report and protect people from the risk of abuse.

We asked the provider if any safeguarding allegations had been made since the last inspection. The provider told us about four allegations of abuse that had been reported. We asked to see the investigation records relating to these incidents. Only one record was available, the other three incidents had not been appropriately documented.

We saw in one person's daily notes that there had been several incidents of a safeguarding nature. We asked the provider for evidence that these incidents had been investigated and reported to the Local Authority Safeguarding Team and the Care Quality Commission. No evidence was available. This meant there was no evidence that appropriate action had been taken in accordance with local safeguarding procedures in order to protect people from harm.

These incidences were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have, and implement, robust systems procedures and systems that made sure people were protected from abuse and improper treatment.

We looked at six people's care files. We saw people's needs and risks were assessed. For example, risks in relation to malnutrition, pressure sores, moving and handling and the person's level of dependency were all assessed. We found that people had more than one risk assessment for each identified risk. In the majority of cases, risk assessments contained contradictory information and staff received little guidance on how to prevent or reduce the risk from occurring. This placed people at risk of inappropriate or unsafe care.

For example, one person had four risks assessments relating to pressure sores. One risk assessment rated the person's risk as high, the other three as medium. All four risk assessments were completed on the same day. Only one contained any risk management actions and these were inadequate and did not describe how the person should be protected. Another person had a mental health condition. One assessment stated they were at medium risk and socially isolated, another indicated they were not at risk and not vulnerable to further decline. There were no risk management plans in place to support the person's emotional well-being. Four people whose care we reviewed displayed challenging behaviours but risk management plans contained little guidance on the level of risks and the risks these behaviours posed to the person, other people who lived at the home or staff or how to manage them safely.

This incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

The premises were not well maintained. They did not provide a clean, safe or comfortable place for people to live in. For example, a number of bedrooms were cluttered and contained trailing electrical wires which posed a trip hazard. Some bedrooms windows were unsafe, some carpets were stained and worn and old furniture and equipment was stored both inside and outside of the

Is the service safe?

home. The majority of toilets did not have toilet roll holders. One toilet did not have a toilet seat, for people to sit on and most of the toilet frames were corroded which made them difficult to clean for infection control purposes

One of the assisted bathrooms at the home was out of use and cluttered with old furniture and equipment which made it inaccessible. This meant there was only one shower room and one communal bathroom for approximately 25 people who lived at the home (four people had their own en-suite facilities). We asked if this had impacted on people's ability to have a bath or a shower. The provider assured us it had not. We checked a sample of six people's personal care charts and saw that the majority of people had not had a bath or a shower for long periods of time. For example, one person had not had a bath or a shower for 51 days, another for 43 days.

The home had a strict no smoking policy. Some of the staff and people who lived at the home were observed smoking outside in the patio area. There were no designated smoking areas or facilities for people or staff to use and smoking paraphernalia was found inside the home. The provider confirmed this. We saw that a risk management plan was in place but the actions identified to keep people safe had not been carried out.

We asked to see the provider's environmental audits that monitored any health and safety risks posed by the environment. The provider told us that no environmental audits were undertaken. The provider's fire risk assessment was not up to date and there were no suitable emergency evacuation procedures in place to tell staff what to do to in the event of an emergency. The personal emergency evacuation plans in people's files did not adequately identify people's support needs and were not easily accessible.

External contractors were employed to test and maintain the home's electrical, moving and handling equipment, fire alarm, bath hoists and the passenger lift to ensure they were safe and suitable for purpose. There was no evidence that the home's gas central heating system had been inspected. This meant there was no evidence the system was safe. The provider told us the system had been tested but could not find the certificate. We were given assurances by the provider that a re-test would be organised without delay.

These incidences were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure the premises and its equipment was clean, safe and suitable for purpose.

After our visit, we contacted the Local Authority and Merseyside Fire and Rescue to discuss our concerns. Merseyside Fire and Rescue undertook a visit to the home and served the provider with a 'Notice of Deficiency' with regards to their fire safety practices and the Local Authority liaised with the provider regarding standards at the home.

We saw that staff had access to personal protective equipment and alcohol hand gels but overall infection control standards at the home were poor. For example, on the first day we visited, we saw that one person's bedroom carpet was stained with what looked like either vomit or ground in food. On our second visit, three days later, the carpet had still not been cleaned and a soiled continence pad was lying on the person's bed. Another person's bedroom bin contained tissues with faecal matter which should have been disposed of in a clinical waste bin. One person's commode had not been cleaned properly and one person's bedroom carpet was sticky under foot.

There were no cleaning schedules in place to ensure that shared equipment such as pressure cushions, mobility aids, and commodes were cleaned appropriately in between use to prevent the spread of infection. Various bedrooms were not adequately clean and parts of the home smelt extremely malodorous. This included the dining room where people ate their meals.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have systems and procedures in place to assess, monitor and prevent the spread of infection.

We asked the provider for evidence that the risk of Legionella in the home's waters systems was monitored. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed. The provider undertook regular checks of the temperature of the water from the tap but these checks alone were not

Inadequate

Is the service safe?

sufficient to manage the risk of infection. After our visit, we referred our concerns to Environmental Health who have visited the provider and identified that a number of improvements needed to be made.

We saw that accidents and incidents logs were completed but there was no monitoring system in place to identify when people had multiple falls of a short period of time so that appropriate action could be taken. This meant some people had not been referred to the Falls Prevention Team for the support they may have required.

We looked at seven staff files and saw that staff were recruited safely. Only one of files we looked at had a contract of employment in place. The majority of people we spoke with said there were enough staff on duty to meet their needs. We saw from staff rotas that the provider, deputy manager/ senior and two care staff were on duty each day with two care staff on duty at night. We asked the provider how they analysed the needs of people to work out safe and sufficient staffing levels. The provider was unable to answer this. We asked the provider how many people required more than one staff member to assist them with their care, the provider was unable to tell us. During our visit we found staffing levels and staff deployment required improvement.

For the majority of the afternoon we sat in the communal lounge or conservatory. We found that staff were not a visible presence in these areas and people often sat for significant periods of time without seeing a member of the care team. This was further complicated by the fact that the majority of the people had mobility problems which meant they were unable to independently access the call bell situated on the wall for help. This meant there was a risk that people needs would go unmet.

Some staff took regular breaks whereas others did not. When we asked the deputy manager how staff breaks were managed to ensure people's needs were met, we were told they were not. There were three incidences where we had to go and find staff to assist people with their personal care needs. In addition we sought assistance for two people asleep in the lounge for long periods of time. These people needed to be checked due to the position in which they were sitting.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to deploy sufficient numbers of suitably trained staff to meet people's needs.

People's medication was kept in a locked medicine trolley which was stored in a secure medication room when not in use. For a significant part of the day the medication trolley was left in the entrance area of the home. The trolley was not secured to the wall to prevent it from being moved. This area was frequently accessed by staff, visitors and other healthcare professionals. This meant there was a risk it could have been moved without authorisation.

We observed the deputy manager administer some people's tea time medication and saw that the way in which the medication was administered by the deputy manager was safe. We checked people's medication administration records and saw that the balance of medication remaining in the medication trolley tallied with what had been administered.

We found a variety of prescribed creams in people's bedrooms. We were told by the provider that no-one at the home self –administered their medication or creams. The provider's medication policy stated that people's capacity and capability to self-administer their medication was to be assessed as safe before people were permitted to store medicines in their own bedrooms. No assessments had been undertaken. We asked for evidence that staff members responsible for the administration of medication were suitably trained and competent. No evidence was available.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the not all medicines were stored securely to protect people from risk and there was no evidence that staff who administered medication were trained and competent to do so.

Inadequate

Is the service effective?

Our findings

All of the people we spoke with told us that staff had the skills to meet their needs. People's comments included "Staff seem to know what they're doing. Carers are excellent"; "Staff have the right attitude to cope with people's needs. They're a fine bunch of girls" and "Oh yes. They're really good". People felt staff knew them well.

We spoke with two care staff and asked them to describe the needs of one of the people they supported. We found that they were familiar with people's needs and the support they required. A GP we spoke with confirmed this. From our observations it was clear staff had good relationships with the people they cared for.

We asked two staff members about the support they received from the provider and deputy manager. One staff member told us they felt supported in their role, the other said they felt supported with certain aspects. Both said they had received supervision and felt the management team were approachable.

We saw that there was some training information in staff files, but this information was inaccurate; did not match staff training certificates and did not show that staff had received an adequate induction or sufficient training to do their job role.

We asked the provider what training was available to staff to ensure they were able to meet people's needs. The provider was unable to tell us. We asked to see a copy of the provider's training schedule showing what training staff had received and when. The provider did not have one. When we asked which staff members had received training in safeguarding, moving and handling and mental capacity, the provider was unable to tell us. We asked the provider how they monitored what training the staff team had to ensure they were able to meet people's needs. The provider told us they did not currently monitor staff training and the training was "A bit hit and miss". This meant the provider did not know if staff team were sufficiently and suitably trained to provide safe and appropriate care.

We saw in four people's accident records that some people had been injured during the provision of moving and handling support. We requested the training records of the staff involved to ensure staff members had been suitably trained in safe moving and handling techniques. The provider was only able to evidence that two of the four staff involved had been trained.

We saw evidence in some staff files that staff had received supervision in their job role by the deputy manager but this required further development. There was no evidence that staff members had their skills appraised with any skill gaps addressed. This meant there was no information as to whether staff had sufficient skills for their job role.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure staff received appropriate training, supervision and appraisal in their job role.

Throughout the day we saw staff seeking people's verbal consent before support was provided. Staff were respectful and supported people at their own pace. One person told us "They (the staff) consult me over everything"; another said "They asked me how I wanted to live and how I wanted to pay". This showed that people who lived at the home were given a choice in how they lived their day to day lives.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) to which DoLS relates is designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS is legislation that is designed to protect people under the MCA who may be deprived of their liberty and ensure that the least restrictive option is taken.

We asked the provider how many people who lived at the home lacked the capacity to make certain decisions. We were told the majority. The provider told us that DoLS applications had been submitted for a number of people at the home to deprive them of their liberty.

We saw in people's care plans that information relating to their ability to make decisions was contradictory. None of the people whose care file we looked at had had their capacity assessed in relation to any aspects of their care. The provider and deputy manager confirmed no-one whose capacity may be in question had had their capacity assessed. Despite this decisions had been made on their

Is the service effective?

behalf. This meant that the principles of the MCA and the DoLS legislation had not been followed and people's human right to consent to their care had not been respected or legally obtained.

For example, four people had had an application submitted to the Local Authority to deprive them of their liberty. No capacity assessment had been undertaken which meant there was no evidence they lacked capacity; no evidence that the decision had been discussed with them, no evidence that any least restrictive options had been explored and no evidence that any discussions to regarding the decision to deprive people of liberty had taken place with either the people themselves or any other persons involved in their care..

One person's Do not Attempt Resuscitation Record (DNAR) stated the person had been consulted with and had consented to, the decision to not resuscitate them in the event of deterioration. The person's care plan held contradictory information as to whether the person had capacity to make this decision and no capacity assessment had been undertaken. Discussions relating to this decision were not documented and the DNAR was unclear as to whether the person had capacity at the time the DNAR was put in place. We asked the provider to clarify the DNAR without delay.

Where people had communication or mental health issues, their care plans contained poor information in relation to their ability to communicate; poor information on how these difficulties impacted on the person's day to day and guidance to staff on how best to support people was poor and generic.

When asked, the provider did not demonstrate a clear understanding of the Mental Capacity Act or Deprivation of Liberty Safeguards. There was little evidence that staff were trained in the Mental Capacity Act, the Deprivation of Liberty Safeguards or dementia care. This meant there was a risk that staff would not know how to care and support people with dementia or mental health conditions that impacted upon their day to day lives.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

People we spoke with spoke highly of the food at the home and told us they received plenty to eat and drink. Their comments included "If a meal doesn't suit me, I'll tell them. Cook comes around with a list if I don't like anything I'll ask for something else"; "Food is excellent. Plenty of tea. I'm the world champion tea drinker. I have as much as I want"; "Choices for meals excellent" and "Food very good. Choices, can't grumble, if extra hungry I get more".

Information about people's special dietary requirements were displayed in the kitchen and catering staff knew what these were. We spoke with the cook who told us that people who required dietary supplements were given fortified prescribed drinks. They said the home also produced milkshakes for people who were at risk of malnutrition which were readily available at any time. We saw that people had free access to drinks throughout the day.

We observed the serving of the lunchtime meal. We saw that the dining room table was decorated with tablecloths, paper napkins and place mats. The dining room was a bit gloomy and in parts smelt malodorous. It was not conducive to a pleasant dining experience.

We saw that people's meals were served promptly and pleasantly by staff. There were three choices on offer on the day of our visit and portion sizes were satisfactory. We heard staff offer people additional portions and alternatives if they did not like what was on offer. The mealtime was unrushed and people were able to take their time to relax after their meal.

People's nutritional needs were assessed but care plans lacked suitable dietary guidance where people were at risk of malnutrition or had special dietary requirements. For example, one person had a medical condition which meant their dietary intake required monitoring. This person's care plan lacked information about what food and drink the person was able to eat; their dietary supplements and how the person's medical condition was managed.

We saw that people were weighed monthly and that GPs were contacted if people's dietary intake significantly reduced. Dietary intake was monitored where there were concerns over weight loss and appropriate referrals to the dietician were made where people required additional support.

Requires improvement

Is the service caring?

Our findings

People we spoke with said they were well looked after. When asked how staff treated them, their comments included "They look after us well. Carers are very considerate anything I want I get"; "Staff always caring. Score 9 out of 10. Very busy in the mornings. In the busy times I may have to wait" and "Treat me very well, very caring. Definitely show respect" and "Marvellous here.

People's relatives and friends also felt staff were caring and respectful. Comments included "All staff are very caring. The way they treat the residents is good, respecting privacy and dignity"; "They're very caring" and "Staff seem very friendly. They (the person) speak highly of staff".

During our visit, we saw that staff interacted with people in a warm and kind manner. From our observations it was clear that staff genuinely cared for the people they looked after and it was obvious that people felt comfortable in their company.

For example we observed an interaction between the deputy manager and a person who lived at the home regarding a planned visit to the bingo. It was clear from observing this interaction that they had a warm and positive relationship. We saw staff talking to people by their first names and using positive touch to reassure people. We saw from one person's activity record that the activities co-ordinator had spent time talking to the person on a one to one basis about a recent bereavement.

We found that staff were not always observant to people's welfare and dignity needs. For example, two people chose to eat their meals in the conservatory at lunch time. One person's meal was served on a coffee table that was too low for the person to eat comfortably from and another person's meal was served on an adjustable table that was set too high for them to easily reach. Neither staff member waited to see if the person was able to eat comfortably before they left the room.

One person told a staff member serving the lunchtime meal that they did not like the food on offer but was not responded to and one staff member made an inappropriate comment to another staff member in a communal corridor. People did not always receive regular baths or showers to maintain their personal care and dignity and some people's continence needs were not adequately addressed as parts of the home smelt malodorous.

In a number of people's bedrooms we found continence products openly displayed for staff, relatives and other visitors to see which did not promote the person's privacy and dignity. During the afternoon we saw private and distressing news was delivered to a person by their relative in a communal setting. No private area was provided by staff despite the person being openly distressed. We asked staff to make a private space available.

Although some of the feedback we received from some people and their relatives indicated that they thought people's independence was promoted, we found that this was not always the case.

We found that care plans failed to clearly outline the tasks people could do independently and what they required help with. The majority of people's mobility equipment was stored in their rooms and the majority of people in communal areas were transported around the home in wheelchairs. We asked about this and we were told that the mobility equipment in people's rooms were spares, used for transferring people to the toilet or to bed. We did not see evidence of any other mobility equipment in use for people in order to promote their independence around the home.

We saw evidence that end of life discussions had taken place with people and their relatives but the information about their end of life care was limited. For example, one person's end of life care simply stated that staff would have monthly meetings to discuss the person's decline in health. No information was provided on the person's end of life wishes or preferences.

We looked at the service user guide given to people on admission. The guide was easy to read but some of the information was out of date. There was no evidence that any resident meetings took place and limited evidence that people's views and suggestions about the care they received were sought and acted upon. This meant the provider failed to ensure people had adequate information or input into the running of the home.

Requires improvement

Is the service caring?

These examples demonstrate a breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.

Inadequate

Is the service responsive?

Our findings

Everyone we spoke with was happy with the care they received. This included people's friends and relatives. One person told us that staff were "Always on hand, I tell them what I want, they don't boss you". One relative told us "They are supported as they like"; another said "Care is good and meets their needs. They have encouraged them (the person) to come out of their room" and a third relative told us "Staff know them very well. There's nothing we couldn't ask them about. They're very open".

We found people's care plans were not person centred and contained little information about the person, their like or dislikes or how they wished to be cared for. They lacked clear information about people's preferred daily routines, people's food and drink preferences or people's wishes with regards to their day to day care. This meant it was difficult to tell if the person had been involved in the planning of their care and if so, what choices they had made.

Care plan guidance for staff was very brief and often generic, meaning that the same 'standard' wording was used in each person's care plan regardless of the person's individual needs and risks. Some people had a 'This is me' document in their care file capturing their life history but this information had not been incorporated in to the person's care plan so that staff had a clear understanding of 'the person' and the care they required and wanted.

We saw that the home employed an activities co-ordinator who undertook a range of activities with people who lived at the home. We saw from people's activity records that the activities co-ordinator worked hard to build up relationships with people and encouraged people join in the activities they enjoyed. On the first day of our visit, a birthday party took place in the conservatory for one of the people at the home, on the second day indoor bowling was enjoyed by a number of people who lived at the home.

Records showed that people had access to medical and specialist support services as and when required for physical health conditions. People we spoke with confirmed this as did their friends and relatives. People's comments included "Yes, doctor comes in regularly"; "Can't fault them with anything. They're very quick and get doctor if needed". People's friends and relatives confirmed this. One friend said "They (the person) were struggling with pain initially but this has improved and they are in less pain now. They had the GP out". The GP we spoke with said "agreed actions are put in place. All staff seem to know residents well".

We found however that access to professional support for people's emotional and mental well-being required improvement and that access to mobility support for people with multiple falls and/or mobility problems were not always pursued in a timely manner.

Some of the people whose care files we looked at, displayed challenging behaviours. Where people had emotional needs or behaviours that challenged, there was no evidence they had been risk assessed and appropriate support planned. There were no behavioural charts in place to monitor people's unwanted behaviours and care plans held no information about the frequency, intensity or triggers to these behaviours in order to assist with their management. There was no person centred guidance for staff on how best to support each person when these behaviours were displayed or the best way to communicate with the person when they became distressed. This placed people at risk of inappropriate or unsafe care.

Some people's geriatric depression assessment indicated that they were low in mood and at risk of a major depressive episode. Despite this the person's plan of care did not provide any information on the person's emotional health, did not cover the areas identified in the person's geriatric depression assessment as an area of concern and offered no guidance on how to care for and support the person's emotional well being. There was also little evidence in people's files that the results of these assessments had been discussed with the person's GP or social worker so that appropriate support could be planned.

For example, one person's file we looked at indicated the person's mental health was very poor and their physical health had started to decline as a result. There was no suitable risk assessment of their emotional well being undertaken to identify the risk of further decline or risk management plan in place to identify any preventative actions. The person's care plan lacked any information on how to support the person emotionally. No referral was made to the safeguarding team to enable a review of the person's needs and care to be undertaken and the person

Inadequate

Is the service responsive?

had not been referred to mental health services in order to support their mental wellbeing. At the time of our visit this person had been admitted to hospital due to a significant decline in their physical health.

One person's mobility had significantly decreased due to a period of ill health. When we asked the provider and deputy manager, what action they had taken to respond to the change in the person's mobility, no satisfactory explanation was given. We asked if a referral to occupational health or the person's GP had been made to access appropriate support for the person's immobility once the person had recovered from their illness. We were told no referrals had been made.

These incidences were a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure people were appropriately assessed and in receipt of person centred care that met their needs and preferences.

No-one we spoke with had any complaints about the care they received but said they would be comfortable raising any issues with "the boss" or other staff. One relative said "No need for a complaint. We sort it at the time"; another said they had raised concerns with regards to the way the person's washing was laundered. They said they now took some of the person's clothing home to wash".

We reviewed the information given to people by the provider in relation to how people could raise concerns or complaints about the care they received. We saw that the provider had two complaints policies in operation. Both were out of date and inadequate.

Both policies lacked important information about who people should contact at the home to make a complaint and only one policy contained details of the organisations outside of the home, that could assist people with any complaints or concerns they may have had. For example, the Local Authority, the Care Quality Commission, Healthwatch England or the Local Government Ombudsman.

Inadequate

Is the service well-led?

Our findings

At the time of our visit there was no registered manager in post. The registered manager left the employment of the provider in October 2014 and had not been replaced. The provider told us they had taken over the role of manager from October onwards. Since October 2014, the Care Quality Commission contacted the provider twice to request that the provider apply for registration as the home's manager. Despite assurances, no application was submitted. During our visit, we asked the provider for evidence that they were suitably qualified and experienced to run the home. No suitable evidence was provided.

We checked what systems the provider had in place to manage the health, welfare and safety risks posed to people who lived at the home. We found a lack of adequate systems. Those systems that were in place were poor and their operation by the provider was not well managed. For example, there were no audit procedures in place for infection control, building safety and staff training and support. Regular audits would have identified the issues we identified during our inspection so corrective action could have been taken.

There were no care plan audits to quality assure the accuracy of people's care planning information. Records relating to people's care were poor and had not been appropriately checked, updated or monitored. This placed people at risk of receiving inappropriate or unsafe care.

The NHS infection control team had audited the home in July 2015. They scored the home poorly for its infection control management (59%), rating it an 'organisational priority'. Following this audit, the provider was required to make a number of improvements to the way in which infection control was managed. They told us they were currently addressing the issues raised by the NHS team but we saw little evidence of this.

We asked to see the provider's action plan on how they planned to ensure the improvements were made. No action plan was available. We spoke to the NHS Infection Control Team after our visit to discuss our concerns. They confirmed that they had yet to receive any adequate communication form the provider with regards to how and when their concerns would be addressed.

The provider told us the assisted bathroom that was out of use was due to be refurbished but failed to produce any formal refurbishment plans for when this work was due to take place. They told us that they were making improvements to the décor and general appearance of the home but again no formal plans were produced to evidence this.

The provider had no systems in place to assess and regularly monitor the sufficiency of staff on duty and had no clear knowledge of people's dependency needs when asked. This meant there was a risk that people's needs would not be met. During our visit we found staffing levels and the deployment of staff poor.

There was no system in place to monitor the number of falls each individual person had to ensure appropriate action was taken. Accidents and incident records were brief and there was no evidence that the provider audited these records with a view to pinpoint any patterns in when or how people fell in order that preventative action could be taken. This meant that there were no effective learning systems in place to identify, assess and manage the risks posed to people using the service from similar incidents occurring.

We reviewed a sample of accident and incident records completed during May to July 2015 and found that three accidents were of a serious nature and had required a hospital visit. These incidents had not been appropriately reported to The Commission as the provider had no system in place to ensure that appropriate referral and notifications were made to the relevant bodies.

Policies and procedures were out of date or not adhered to by the provider and the staff team. For example, the provider's medication policy stated the procedure to be followed for people to self-administer their own medication but this was not followed. The provider's smoking policy clearly stated no smoking inside the building but this was not adhered to. The provider's safeguarding policy clearly stated the process to follow in responding to and reporting safeguarding incidents but this had not been followed. By not doing so, they placed people at risk of harm.

When requested, the provider's complaint records could not be found. The provider told us that two complaints had been received and that they had been satisfactorily dealt

Inadequate

Is the service well-led?

with. We were unable to verify this, as no records had been maintained. This showed that the provider's system for responding to people's negative feedback in order to improve the service was inadequate.

These incidences were a breach of breach of 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have effective systems in place to identify, assess and manage the risks relating to the health, welfare and safety of people at the home.

The manager told us a satisfaction questionnaire had recently been sent out to people but at the time of our visit only two questionnaires had been completed and returned. Both indicated people were satisfied with the service they received.

During our visit we found the culture of the home to be positive and inclusive. Staff were friendly, welcoming and hospitable to visitors. They were observed to have good relations with each other and were caring and warm in all their interactions with people at the home. We found both the provider and deputy manager approachable and this was confirmed by staff at the home. At the end of visit, we discussed with the provider and deputy manager, the areas of serious concern identified during our inspection.

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 9 HSCA (RA) Regulations 2014 Person-centred care People were not protected against the risks of receiving inappropriate or unsafe care as the design and delivery of care did not meet all of the person's individual needs, preferences and risks. Regulation 9(1)(a)(b)(c) and 9(3)(b).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always treated with dignity and respect in their day to day care. Regulation 10(1)

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There were no suitable arrangements in place to ensure that the service obtained the consent of, and acted in accordance with the consent of people who lived at the home. Regulation 11(1),(2),(3)(4) and (5).

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's health and welfare risks had not been properly assessed or mitigated against in the planning and delivery of care Regulation 12(1) and 12(2)(a) and (b).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines at the home were not always managed in a proper or safe way. There was no evidence that staff were suitably trained or competent to administer medicines. Regulation 12(2)(g).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control There no arrangements in place to assess, prevent and detect the risk of infection or controls to prevent its spread at the home.

This section is primarily information for the provider

Enforcement actions

Regulation 12(2)(h).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

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 There were no established systems in place to effectively record, investigate, act upon prevent and report any allegations of abuse in order to protect people from potential harm. Regulation 13(1)(2)(3).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises There were no effective systems in place to ensure that the premises and equipment used at the home was clean, suitable for purpose and properly maintained. Regulation 15(1)(a)(c) and (e).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider did not have effective systems in place to assess and monitor their service against Health and Social Care Act Regulations or to assess, monitor and mitigate the risks to the health, safety and welfare of people who used the service.

Regulation 17(1),(2)(b).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider failed to have sufficient number of suitably trained staff on duty to meet people's needs. Staff had not received appropriate training, supervision and appraisal in relation to their job role. Regulation 18(1),(2)(a).

The enforcement action we took:
As the overall rating for this service is Inadequate, we have decided that the service will be placed into special measures. Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.