Mr & Mrs P Gungaloo

The Barn House

Inspection report

Quality street
Merstham
Redhill
Surrey
RH1 3BB
Tel: 01737643273
Website:

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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?	Requires improvement

Overall summary

The Barn House provides care and accommodation for up to 30 people and is registered to provide nursing care for people with physical disabilities, mental health issues and those who may be living with dementia. On the day of our inspection 25 people were living at the service.

The inspection took place on the 21 April 2015 and was unannounced.

The service is run by a registered manager, who was present on the day of the inspection visit. 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 and associated Regulations about how the service is run.

People had different levels of understanding and communication in relation to their dementia. Staff did not show a level of understanding that people living with dementia have specialist needs.

Summary of findings

Staff did not have written information about risks to people and how to manage these in order to keep people safe. One person had been diagnosed with epilepsy, but their care plan did not describe guidance to staff on how to manage the risks of this person having a seizure. Another person had been diagnosed with diabetes and their care plan did not specify the management of this. Risk assessments and care plans did not reflect the individual need of the person and how their dementia, mental health and physical needs affected their daily life.

Staff had received training in safeguarding adults and were able to evidence to us they knew the procedures to follow should they have any concerns. One staff member said they would report any concerns to the registered manager. They knew of the types of abuse and where to find contact numbers and knew about the local safeguarding team. However, we found the provider had not submitted notifications of safeguarding concerns to the Care Quality Commission (CQC) in a timely manner.

Staff did have awareness training for with caring for people who live with dementia; however the organisational culture did not support the development of staff's practical and competency skills when working directly with people.

We saw staff were not effectively deployed as there were times when we found no staff available to assist people or keep them safe. For example, from the risks of falls, or to support someone if they became distressed. We observed when people were able to access the garden one resident fell off a garden chair as there were no staff to supervise them. This required intervention from the inspector.

The premises were not safe or well designed to enable people with mobility needs or dementia to be as independent as possible for as long as possible.

People spoke to us about living at The Barn House. One person said; "You get used to it. You're just here and that's it." We did not observe staff consistently respecting people and treating them as individual's, focusing on their needs, abilities and achievements. We heard staff ask people constantly about task focused activities, for example, "Come and have your dinner" and, "Take your medicines."

Staff did not show an understanding of what people were interested in and what people could still do. We saw some people sitting for long periods of time without supportive interaction from staff. Supportive interactions are relationships and communications that we have with people that are affirming and help promote a person's sense of self-worth. Best practice guidance shows one-on-one time is very important to having supportive and emotionally worthwhile social interactions.

Activities were limited to people who had capacity to become involved. We did not see any specific activities or pastimes which would be suitable or appropriate to people living with dementia. One member of staff said there were not enough activities. One person said, "I sit here and watch the television, that's all." When asked what activities they would like if given the choice, they said, "Go in the garden." We asked them how often they go into the garden and they told us, "Not much. They take us out in the summer. That's all."

People were offered a choice of food. However, we observed that people were not supported to eat in a dignified way. Staff were not aware of people's specialised dietary requirements such as the need for thickened fluids to reduce the risk of choking.

Medicine procedures for the safe administration of medicines were in place. However we identified some shortfalls in the recording of medicines on the medicine administration chart (MAR).

People were referred to some external health professionals when they needed extra support but not in a timely manner, or if they had specialised needs. One person said, "I don't think the external professionals fully understand the complexity of my physical healthcare needs."

Care plans did not reflect people's current needs or individualised choices. They had not been reviewed on a regular basis and people were not involved with their own plan of care. One person said, "What's that? Never heard of it."

The legal framework around the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) had not been followed. The provider and staff did not consistently understand the requirements of the Act and how it affected their work on a day to day basis. Three staff had an understanding and was able to describe some of the residents needs appropriately. They said they had training in MCA. However the registered manager had

Summary of findings

not completed the necessary MCA two-stage assessment or applications to the local authority as required by the DoLS. This meant people without capacity had not been supported in agreeing to choices made about their care.

The registered manager did not have a satisfactory system of auditing in place to regularly assess and monitor the quality of the service or manage risks to people in carrying out the regulated activity. We found the registered manager had not undertaken actions suggested in external risk assessments for example signs in the corridors. And to make sure improvements to practice were being made.

People's views had not been obtained by holding residents meetings and sending out an annual satisfaction survey.

Confidential and procedural documents were stored safely. We saw copies of the services contingency and emergency plan and the registered manager was able to explain the process in the event of an emergency.

Staff recruitment processes were robust to help ensure the provider only employed suitable people.

Staff had mixed views on the management of the service generally said they felt supported. Staff said they had received regular supervisions. One staff member said, "The registered manager makes me feel confident and supported." However other staff felt the registered manager could be, "Very sharp and that some staff were afraid to speak."

People said staff were caring, and that visitors were welcome at any time.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person has a rating of 'Inadequate' for the key questions 'safe' and' well led' at the last inspection and this inspection. 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.You can see what action we told the provider to take at the back of the full version of this report.

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.

Risks to people's health and welfare were not always minimised effectively.

The provider had not ensured there were staff effectively deployed to meet people's needs.

The environment was not a safe environment for people with dementia or mobility needs. T

Medicines were not received and managed appropriately.

environment for people with dementia.

Staff knew how to recognise the signs of abuse and would report any concerns they had. The provider had not notified CQC of safeguarding concerns in a timely manner.

The provider carried out appropriate checks to help ensure they employed

suitable people to work at the service.

Is the service effective?

Inadequate 

The service was not effective.

Staff were not effectively monitoring people's healthcare needs, particularly when their needs changed.

Staff did not demonstrate best practice in relation to working with people living with dementia or mental health issues.

People did not receive the appropriate support in ensuring they had enough drink. Staff did not follow guidance on people who needed specialist diets.

The registered manager did not understand their responsibilities under the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards. People's freedom was being restricted and there was no system in place to identify if people could make decisions about their care and treatment.

Staff had received regular supervisions and training.

Is the service caring?

Requires improvement 

The service was not caring.

People were not consistently positive about the care they received, and this was supported by our observations.

People's privacy was not always respected by the way that care was provided, however people were not always treated in a dignified way.

Summary of findings

Some staff showed concern for people in a caring way; however practical action was not always taken to relieve people's distress.

Is the service responsive?

Inadequate

The service was not responsive

Care plans were not person centred and had not been regularly reviewed to help ensure staff had up to date guidance on people's needs.

People had not been supported in contributing to planning their own care.

People were not always supported to take part in activities and there were no individualised activities for people.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

The registered manager had not always ensured that effective quality assurance systems were in place to identify and remedy areas of concern or risk in a proactive manner.

The registered manager and provider did not understand their legal responsibilities or have a good understanding of the key challenges, achievements, concerns and risks.

Notifications of incidents were not submitted to the CQC as required by law.

The Barn House

Detailed findings

Background to this inspection

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

The inspection took place on 21 April 2015 and was unannounced. The inspection was carried out by two inspectors and an expert by experience (ExE). An expert by experience is a person who has personal experience of using, or caring for someone, who uses this type of care service

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) because we were responding to information and concerns that had been raised with us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We looked at documents which included five people's care plans, three staff files, training programmes, medicine records, and four weeks of duty rotas, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did.

During the inspection we spoke with 11 people who used the service, four staff, two relatives, the registered manager, the registered provider and health care professionals. We observed care and support in communal areas and looked around all areas of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us

We last inspected The Barn House on 26 November 2013 where we had no concerns.

Inadequate

Is the service safe?

Our findings

One person told us, “Yes, its safe here” while another person said, “I feel okay here.” A relative said, “My family member is very safe.” Staff said they felt the service was safe. One person said, “Sometimes things are wrong with me and I get worried and shout. The staff don't help.”

Despite these comments people were not always kept safe. Whilst there were enough staff employed by the provider they were not always deployed to safely meet people’s needs. The provider told us that there should be one nurse and four care staff during the day and one nurse and two care staff at night which was the case on our inspection however the provider had not used a dependency tool to assess what safe staffing levels would be.

Some people were isolated in their rooms on upper floors of the home and we did not observe that staff were regularly monitoring or checking these people on a regular basis.

We observed several instances that required us to intervene to make sure people were kept safe. One person did not have a call bell within reach and was calling out repeatedly for ten minutes before staff responded. On another occasion a person stated they were cold and would like a drink however staff did not respond for over 20 minutes. Staff had not been deployed to check regularly on people who remained in their rooms.

People had been encouraged to go into the garden for afternoon tea and had been left without appropriate staff support one person fell off a garden chair however there were no staff available to help them. This required us to intervene to summon staff to help the person. The registered manager had not ensured the safety of people was protected by ensuring staff were deployed effectively throughout the service.

This is a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The provider carried out appropriate checks to ensure they employed staff that were suitable to support people at the home. Staff told us they had an interview before they started work and had to provide evidence to support their application. All the staff files we looked at had the necessary documentation needed such as proof of identity, references, work history and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services.

People were not protected against the risks of living in unsafe premises. The premises were not designed to enable people with mobility needs or dementia to be kept safe. The service had narrow, dimly lit hallways which had dark maroon carpeting with a number of slopes and uneven areas of flooring. We observed people stumble on occasions whilst walking through the corridors and there was a risk to people with limited mobility who were at risk of falling. One person said, “'It's awkward getting into the garden.” There was a large ‘lump’ in the floor which presented a trip hazard as it was not easy for people to see.

People were not always kept safe because the provider had not taken reasonable steps to assess risks to their health and risks caused by the environment of the home. One person had been diagnosed with epilepsy and had experienced seizures, but their care plan did not describe guidance to staff on how to manage the risks of this. Some risk assessments had been completed for example in relation to pressure sores and manual handling however these had not been updated regularly to ensure they were current. There was a smoking room available that people used however this was in a poor state of repair. The floor was tiled with cigarette marks on it. The furniture contained burn marks. Restrictors were fitted to windows to protect people from falling from them however we found that some were not sufficiently robust to prevent people falling. The provider told us that they would address this.

Medicines in the home were not always administered safely. We observed lunch time medicines being administered and saw that the nurse did not check the person took their medicines before signing the medicines administration record (MAR) chart. People were also at risk of being given the wrong medicine because MAR charts either had an out of date picture of the person or did not have a picture of them at all. MAR charts did not detail people’s allergies and there was a lack of information available to guide staff on how certain medicines were administered. Medicines used ‘as required’ did not always have guidance available for staff on how and when the medicine should be given which resulted in one person

Inadequate

Is the service safe?

being given a laxative daily in error. One MAR chart had not been signed for a period of 10 days. We checked that the person had received their medicines correctly which they had.

The temperature of the room that medicines were stored in was hot which could have affected how the medicines worked. Staff did not monitor the temperature of the room and only checked the temperature of the medicines that were stored in the fridge. Some medicines had not had a record made of when they had been started which meant that people could have been given medicine that was out of date or was no longer effective whilst one person had not had it recorded for a two week period that they had received their medicines so it was unclear whether they had received them or not.

This is a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of abuse. Whilst staff had received safeguarding training they did not always know who they should report concerns to and were not confident about doing so. There was no information readily available to help guide people or staff should they wish to raise a concern. The provider did not always understand their responsibilities in relation to safeguarding and as a result incidents had not been reported appropriately.

This is a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People told us that they can't always make the choices that they want. One person said, ". They tell me when I can smoke and when I can go out." Whilst another said "They don't let me go out on my own".

Not everyone had capacity to make decisions about the care and treatment they received. The provider did not have suitable arrangements in place to ensure that staff obtained consent from people and as a result people faced daily restrictions on how they lived their lives. One person had their cigarettes 'rationed' and was only given them on certain days. The provider had not considered or undertaken an assessment to determine whether the person was able to make the decision to smoke and said that he "felt they lacked capacity." Another person who lacked capacity needed to have regular screening for a health condition as their lifestyle could make their condition worse. The persons GP had determined they lacked capacity about the treatment choices available to them however the provider had not taken any action to arrange a best interest meeting to ensure the person's health was maintained as they said they were "Difficult" when the they spoke to them about this.

Staff had a variable understanding of the Mental Capacity Act 2005 (MCA) whilst one member of staff knew how to ensure they followed the MCA and gave people choices and asked for their consent other staff did no which impacted on how people lived.

The provider and registered manager did not have a clear understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). They told us they had made applications to the local authority for those people who lacked capacity where restrictions had been placed on them. However they were unable to provide evidence of why the applications had been made and what they were for.

These are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback in relation to the food. One person said "There're a lot of curries, you get used to them", 'If you don't like the hot stuff, they give you sandwiches. "One person said, "It's usually okay" whilst another said, "I like the food, everybody had a menu and I choose my own."

We observed lunchtime. The dining area was uninviting. There were plastic table cloths on the tables, plastic beakers for people to drink from, and the table was not laid. We saw that mealtimes were not always a pleasant experience with staff not interacting with people when they supported them to eat. Meals were served at different times with those that needed support to eat being served first. People who could eat independently had lunch in the upstairs dining room. We saw that the food looked unappetising for people who required a pureed diet as their food was served mixed together in a bowl.

Staff did not always have the knowledge required to support people with special requirements, one person required a thickener in their drink but this had not been provided to them and they were coughing whilst they were drinking. This meant that staff had not followed the guidance in care plans to reduce the risk of choking to the person which stated that drinks should be thickened at all times. We reported this to the registered manager to ensure that staff were made aware of this person's needs.

People's nutritional care plans were not consistently kept up to date; one person's food and nutritional risk assessment was last updated in January 2015, the person had been assessed as having special dietary requirements and the care plan had not been reviewed on a monthly basis to reflect any changes in the person's needs. One person's nutritional care plan had been reviewed in July 2014 where staff had identified that they may require a pureed diet. However this person was not referred to the speech and language therapy (SALT) team until April 2015 putting the person at risk of choking. Documents that helped reduce the risk of malnutrition were not updated and the provider had not identified risks to people with complex needs in their eating and drinking.

This is a breach of Regulation 14 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

People did not always get support to manage their healthcare needs. One person with diabetes had not had their blood glucose levels measured for over six months. It is essential that people with diabetes have their blood sugar tested to ensure their health is managed and to prevent long-term complications from the condition. We asked the provider to take steps to ensure that this was done in future.

Inadequate

Is the service effective?

Staff regularly requested the GP to visit however staff did not respond to changes in people's health needs. People were not supported to be referred to specialist healthcare appointments such as diabetic, epilepsy or Parkinson nurse to help support their complex needs. One person told us, "My physical needs are not managed here; they're not cared for here." And, "I see the doctor but I have little confidence in the staff management of my needs." A healthcare professional said that the home has a high level of calls to the emergency services and that service did not always cope well with people with complex physical needs.

Staff had the regular opportunity to develop their skills through distance training and e learning. The registered manager did not undertake competency assessments of staff to ensure they were putting the theoretical learning into best practice. From our observations staff did not fully understand or consistently demonstrate their knowledge or how to put their training into best practice. For example, at lunch time one staff member was heard saying to a person, "Come and have your lunch upstairs now." Although the person refused, the staff member continued saying, "Come now." We observed the person became very agitated as they clearly did not comprehend what the staff member was asking. Staff had not tried to support the person with other activities or to distract the person from the anxieties they showed.

The registered manager said that staff had regular supervision. Staff told us, "I have regular supervisions, the registered manager makes sure that the tasks each care staff had were, well defined so that everyone knew what they were doing and when." Staff said there were quarterly staff meetings.

Requires improvement

Is the service caring?

Our findings

People had mixed views about the quality of staff, one person said, “They (staff) talk to me and comfort me sometimes.” They added, “They're caring if I'm upset about something.” The person also said that “The staff do a lot for me.” However another person said, “They don't understand. They really don't understand my impairment. They're not clued up.”

One healthcare professional said it was a nice place and the staff were very good. They said they felt the level of care was good for people with mental health needs, but lacked in the knowledge to support their physical needs. One person said, “I feel lonely at The Barn House, and out of place here.” They told us they didn’t believe they should have been moved to The Barn House as their physical healthcare needs were so high.

Although we observed some staff treated people with dignity, this was not always consistent. Staff did not support people to go to the toilet. The provider had not ensured the service was free from preventable offensive odours. The downstairs area of the service had a strong odour of urine. We spoke to the registered manager who told us that people did not always use the toilets provided. However we observed there were no signs to indicate to people where toilets were situated. The housekeeper told us “I only use air freshener” to manage the smell and did not use any specialist deodorizing products or neutralisers.

We observed staff undertaking gentle exercises with one person but they did not encourage or explain to the person what they were doing. We asked the staff member if they had specific training in these exercises or an understanding of the person’s health needs and they said they did not.

We observed at lunchtime that staff stood beside one person who needed support and did not sit next to them. One person was very sleepy at lunchtime, and had difficulty sitting in an upright position. Staff had their leg against the person to stop them falling over whilst assisting them to eat. The staff member kept saying “Wake up, have your lunch.” We asked staff why this person was not sitting in a chair with arms and staff said, “I don’t know.”

People’s rooms had jugs of water and glasses on their tables however these were placed out of reach to them.

One person who had limited mobility was sitting in a recliner chair and their drink was out of reach whilst another who was in bed had a jug of water but no glass to drink the water from.

People did not have the facilities to make their own drinks or snacks so they were not able to be as independent as they wpuld have liked and there were set routines which affected how people accessed food and drink. On one occasion one member of staff was walking through the corridor with a tray of tea. A person reached out to indicate they wished a drink, but they told the person they couldn’t have a drink until later. No attempt was made to offer them a cup of tea or drink. We asked the staff member how people (who were able to) could make their own drinks if they wanted to. They said, “They don't make their own, they don't need to because we do it.”

The provider had put in place a rules and a way of doing things that had a detrimental impact on someone with a protected characteristic such as a disability. There appeared to be a set regime in the house which people were not involved in deciding. For example, time for getting up, drink times, medicine times and activity times. People did not realise they did not have to follow this because an alternative choice was not offered.

Staff did not always spend time with people socially and we did not see many occasions when staff sat and interacted with people. Staff told us that they may not have time to sit with people as people had differing level of needs throughout the service.

People privacy in the service was not always respected. We saw toilet doors had no internal locks on them or signs that showed someone was in there. We observed the housekeeper cleaning two people’s rooms while they were asleep in bed. We asked them if they had asked the person if they minded having their room cleaned at that time. The housekeeper told us, “No, I have been told to clean the rooms, it’s my job.”

The lack of consideration and respect to people is a breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We also saw some good examples where staff were kind and patient with people. We observed one member of staff ask a person about some difficulty they had with their feet. They helped the person to remove their shoe and waited patiently for them to explain what was happening. When

Requires improvement

Is the service caring?

the person dropped their sock on a chair, the staff member very thoughtfully suggested they move it as other people had to sit there. The staff member's voice remained low and they spoke in a caring manner.

Inadequate

Is the service responsive?

Our findings

One person said that they did not go out and, "I prefer not to do the activities here." When asked why, they said, "They don't interest me." Another person said, "I sit here and watch the television, that's all."

In the afternoon we observed there were no activities in either the lounge or garden, although a member of staff did ask people if they would like to have their tea outside in the garden that day.

The registered manager said the service did not have a dedicated activities staff member. The provider said that although some activities were provided it was, "Difficult to do" some (activities) and they had been advertising for an activities coordinator for, "Sometime". However the provider said the YMCA attended the service once a week and there were exercise and ball games, music and 'sing songs' and table cricket. Some people went out shopping and one person went out independently three times a week.

We used the Short Observational Framework for Inspection (SOFI). We saw people sitting in the lounge areas for the majority of the day. Three people were asleep from lack of stimulation. The TV was on however people told us they didn't know why it was on, who put it on and they weren't watching it.

Activities had not been tailored to people's individual needs and limitations. For example, people were asked to take part in a skittles game however they were not age appropriate. This showed us that encouraging people to be involved by finding meaningful activities was not promoted by staff.

The environment lacked stimulation for people living with dementia and did not build on people's remaining skills and talents. For example, labelling cupboards and drawers or using pictures and words. We observed several people in the service walking throughout the day looking for their rooms.

We recommend that the registered manager explores relevant guidance on how to make the environment more dementia friendly and to look at guidance about meaningful activities for people living with dementia.

People's needs had not always been appropriately assessed before they moved to the service. One person said, "Management didn't make an assessment when I first came. They didn't, and still don't understand my impairment." We asked people and family members if they had been involved in planning the care of their relative. Relatives said they were included and kept up to date by the staff at the service. However people who lived at The Barn House stated they had not been involved in planning their care. One person said, "I don't have one of those." Another person said, "I don't get asked about the care that I want."

We saw care plans contained incomplete pre-admission assessments and lack of detail about what care was to be provided to people. The provider told us that currently a safeguarding investigation was on-going with the local authority regarding one person who had been admitted to the service without a pre-admission assessment and their needs had not been met.

Care plans had not been reviewed regularly and did not always provide clear direction for staff in what care to provide for a person. One person with epilepsy and behaviour that may challenge others did not have a care plan in place to tell staff how to meet their needs. The provider said they thought this person had a seizure in November 2014 but they weren't sure. No action had been taken to follow this up with their GP despite there being a note that the GP should visit.

Care plans had not been reviewed for staff to be guided in managing behaviour that challenges others or how medicines may affect people. One person went out of the service three to four times per week, often to London. There were no risk assessments in relation to the person being in the community. In the care notes there was a note the police had been called on April 2015 as the person had an episode where they had 'delusions and paranoid ideas'. As a result this person's medicines had been increased but there was no evidence that consideration had been given to how this might affect this person continuing to access the community.

Care plans lacked personalisation and primarily focused on tasks such as personal care and mobility needs. They did not show how the experience of dementia or people's mental health illness affected people as this varied widely from person to person. Care plans lacked an element of dementia focused care information such as memory assessments, biographies and personality traits.

Inadequate

Is the service responsive?

Care plans were not appropriate to meet people's needs or reflected people's preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's views were not obtained and they were not asked to complete feedback questionnaires so that they could give an opinion on how they wanted their care to be delivered. There were no resident's meetings however the registered manager said they would be starting this process within the next few months.

Relatives said that they have not had a need to complain, but would approach the registered manager if there were any issues. The registered manager said there were no on-going complaints at present and that staff and people come directly to them if they had a complaint and they would try to resolve it informally. There was a complaints policy available to people and relatives which explained what they should do if they needed to raise a complaint formally.

Requires improvement

Is the service well-led?

Our findings

People said, “I don't talk to the managers because they simply don't understand me.” Staff had mixed views about the support from the provider and registered manager. Relatives told us the registered manager was, “Always around.” Most staff felt the registered manager was approachable and supportive most of the time however some staff felt they, “Blamed staff when things had gone wrong.”

Staff generally felt supported but not all staff understood their roles and responsibilities. Staff felt their views were not always sought and valued. The culture of the service is not always open and transparent. Communication may sometimes be unclear. When people are involved it tends to be those with a stronger voice who are listened to.

The provider had procedures and documents in place to assess the quality of the service and identify any areas of concern. However the registered manager had not undertaken the audit schedule as requested by the provider and audits in relation to care plans, infection control and other audits had not been regularly undertaken. Quality assurance systems had not ensured that people were protected against some key risks as described in this report. For example, in relation to care plans reviews, cleanliness and the Mental Capacity Act 2005. For example, if regular care plans audits had been undertaken they would have identified the lack of appropriate reviews and dietary requirements for people. Regular monitoring of staff practice in relation to activities would have identified that some people were not being supported to have ‘quality’ days.

The provider had asked an external health and safety consultant to undertake an audit on the service; however actions identified from this audit had not been completed. For example risk assessments for manual handling, lone working and violence and aggression were required. The document also stated employers must indicate areas at risk by displaying signs and pictures to keep people safe.

The provider and registered manager were reactive rather than proactive and did not always identify risks, and they did not have strategies to minimise these risks to make sure the service runs smoothly. There had been incidents within the service but the provider had not submitted the appropriate notification to CQC as required by law. For example, incidents where the police had been involved and safeguarding concerns. This showed the provider was not meeting their legal requirements within their registration or monitoring or mitigating the risk to people in relation to health, safety and welfare.

The registered manager did not effectively undertake processes to regularly assess and monitor the quality of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered manager knew people’s name and information about their needs and lives and they interacted with people in a kind and compassionate way. We saw that they walked around the service regularly and observed staff interactions and care to ensure that the quality of care was provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not protected against the risk of unsafe care or treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The respect and involvement of people was not met as staff did not always treat service users with consideration and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered manager had not ensured that care plans were appropriate, met people's needs or reflected people's preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider had not identified risks to people with complex needs in their eating and drinking.**

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

Action we have told the provider to take

The registered manager did not effectively undertake processes to regularly assess and monitor the quality of the services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider did not ensure there were enough staff deployed to keep people safe .

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 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Where people did not have the capacity to consent, the provider and registered manager was not acting in accordance to legal requirements.

The enforcement action we took:
We have sent a warning notice to the provider notifying them that they are failing to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have told the provider they are required to become compliant with the regulation by the 15 August 2015.