Samalodge Limited

Anita Jane's Lodge

Inspection report

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Ratings

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

Overall summary

We inspected Anita Janes Lodge on 9 and 12 October 2015. The inspection was unannounced. Anita Janes Lodge provides accommodation for persons who require personal care.

We carried out an unannounced inspection of this service in May 2015. A breach of legal requirements was found. The registered person had not ensured that incidents of concern had been reported to relevant agencies so that care could be monitored and measures put in place to manage risks to people.

After this inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. At this inspection we found the provider had met this breach as staff had reported these issues to relevant agencies.

We undertook this unannounced inspection to check that they had followed their plan and to confirm they now met legal requirements.

Anita Jane's Lodge is a residential care home for up to for sixteen adults with mental health needs. There is a lounge/dining room on the ground floor, and bedrooms

Summary of findings

on the ground and first floors. To the rear of the home is a large secluded garden with a patio. The home is situated on the Uppingham Road in Leicester close to shops, parks, and bus routes.

On this inspection we found breaches of the Health and Social Care Act 2008 Regulated Activities Regulations 2014 with regard to providing safe care and ensuring that people receive a quality service. You can see what action we have told the provider to take at the back of the full version of this report.

A registered manager was not in place. 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. At the time of the inspection the manager had applied to the Care Quality Commission to become the registered manager.

People using the service and relatives we spoke with said they thought the home was safe. Staff were trained in safeguarding (protecting people from abuse) and understood their responsibilities in this area.

Staffing levels were not sufficient to provide proper care to people. Staff that were on duty on their own had minimal experience and had not been sufficiently trained to deal with emergency situations.

Staff were not able to meet people's care needs promptly and did not have the time to meaningfully engage with people and take a full interest in their lives. This meant the people at the home did not always feel valued and their quality of life had not improved as a result.

During the inspection we did not see many examples of staff engaging with people and supporting them to pursue hobbies and interests. Some people told us they did not have much to do or activities to look forward to.

This was not a home where, as part of their normal duties, staff continually engaged and interacted with the people using the service, although we saw that staff were caring in their approach to the people they supported. They knew and understood people and their personal characteristics.

When lunch was served staff gave people a choice of menu. The food was not freshly cooked and did not look or smell particularly appetising though there were sufficient quantities, and people ate well.

Records showed that the service's training programme had been improved and extended since we last inspected. Staff told us they were satisfied with the training they had though not everyone had training on all essential issues such as first aid.

Staff were knowledgeable about people's health care needs and ensured they saw healthcare professionals when they needed to. Staff reported to health and social care staff if any incidents had happened which were a risk to people. If people needed to go to a GP appointment or to hospital and had no family member who could take them, staff from the home accompanied them.

Activities were not a big part of life in the home and some people using the service and staff wanted more activities and outings, such as having table tennis equipment and going out for meals.

People told us if they had any complaints or if there was anything bothering them they would tell the manager or another member of staff. The manager told us she had an 'open door' policy and people and relatives could come and see her at any time if they were unhappy about any aspect of the service.

Quality assurance audits had been carried out on a range of issues but action had not always been taken to deal with any issues. For example, information in the staff questionnaires had stated more activities were needed and teamwork between staff needed to be improved. However, there was no evidence these issues had been acted upon.

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?

Requires improvement 

The service was not consistently safe.

There were not enough staff on duty. Inexperienced staff were on duty on their own. Care planning to prevent risks to people's safety was not fully in place. Some improvements were needed to the way medicines were managed in the home. Improved fire safety was needed to ensure people were protected from fire risks. The home was not kept clean which posed infection risks for people.

People felt safe in the home and staff knew what to do if they were concerned about people's welfare. Staff were safety recruited to help ensure they were appropriate to work with the people who used the service.

Is the service effective?

Requires improvement 

The service was not consistently effective.

Staff were not been fully trained and supported to enable them to care for people to an appropriate standard.

People's consent to care and treatment was not fully in line with legislation and guidance.

People had plenty to eat and drink but the quality of food supplied was predominantly processed with little fresh food.

People were referred to health care professionals when necessary. Staff had responded to ensure people's health needs were protected.

Is the service caring?

Requires improvement 

The service was not always caring.

People said the staff were caring and friendly. We saw instances of staff providing people with dignified care. However, people's privacy have not always been preserved.

People and their relatives were not always involved in making decisions about their care.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

People did not always receive personalised care that met their needs.

Activities were not consistently provided to people using the service.

Concerns expressed by complainants had been investigated but not always responded to.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

People had opportunities to share their views about the service but these had not always been acted upon by the provider.

Management carried out audits and checks to ensure the home was running smoothly though not all issues had been checked or actioned.

Requires improvement

Anita Jane's Lodge

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 Regulated Activities Regulations 2014, 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 9 and 12 October 2015 and was unannounced. The inspection team consisted of an inspector, a specialist adviser, and an expert by experience. A specialist adviser is an expert in the care of people who may lack capacity to make decisions for themselves. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the notifications we had been sent. Notifications are changes, events or incidents that providers must tell us about.

We used a variety of methods to inspect the service. We spoke with seven people using the service, four relatives, the manager, the deputy manager, the area manager, the company secretary, three care workers, two health professional, and one social worker.

We observed people being supported in the lounge and dining area. We looked at records relating to all aspects of the service including care, staffing, medication and quality assurance. We also looked in detail at three people's care records.

Requires improvement

Is the service safe?

Our findings

Although people thought they were safe living in the service, we found aspects of care that were a risk to people's safety.

One person was using a method of mobilising that was potentially unsafe to both themselves and the staff supporting them. One staff member said the method used ''pulls [the person's] arm''. Although staff said this person's mobility was decreasing no assessment for a new walking aid had been carried out and medical records relating to this person's mobility could not be found. This was a risk to the safety of the person and staff assisting them.

The staff we spoke with said that they thought people were safe living in the home. However, we observed numerous requests for assistance made by various people living at the home. Such requests could not always be met in a timely way by the two staff on duty due to many other tasks they had to carry out including domestic and catering duties which took them away from providing care to people. At breakfast for example, food was being prepared by one staff member. At the same time, the other staff member was administering medication. This meant that if someone's behaviour needed to be managed, or if someone required assistance with care, no staff were available to offer support. Staff on duty were observed to be working constantly and conscientiously. However, we saw many occasions when staff had not been present in the main lounge to ensure people were safely protected from the behaviour of some people living in the home.

We found that when one staff was preparing food and the other was administering medication, there was no-one available to meet people's needs. At other times when one staff member was seeking to re-direct someone's behaviour and the other staff member was assisting someone with their care, there was no-one available to respond to other needs. Some people asked several times for their cigarettes or personal funds and such requests were often denied because of the priority of other needs. Two people living at the home were observed as having significant mobility difficulties and needing assistance or reassurance to walk. They were affected by the inability of staff being able to respond to their needs and to maintain their safety.

We observed a person who smoked being told by staff that they could give him a light for his cigarette. They told us, due to his risk assessment, that he could not hold or keep a lighter. However, later in the day the person was observed having access to a lighter by picking one up the table in the courtyard and lighting a cigarette. This lack of staff presence meant there was a risk to people's safety.

Staff told us there had been a reduction of staff in the past few months on both daytime and night time shifts, due to the reduced numbers of people living there. However, two more people had recently been admitted into the home, with no increase in staffing levels. We looked at night staffing levels. There was one waking night staff with on-call management staff available. However, when we spoke with the manager about people's dependencies and those people with behaviour that challenged the service, and what would happen if the only staff member at night was incapacitated in anyway, the manager agreed this could be a risk to people's safety. She said she would speak with the senior management of the company and request for more staff to be employed on day and night times.

The provider contacted us after the inspection. He stated that an additional staff member would be employed to work when the manager had time off and an activities coordinator would also be employed. He stated that there were sufficient night staff arrangements as another service owned by the company contacted the home every 15 minutes and if there was no response the on-call person could get to the home within 45 minutes. Also that if the waking night staff needed assistance they could page the on-call person. Whilst we recognise that these on-call arrangements provide a support service, they do not appear sufficient to protect people safety.

We looked at the staff rota. We found that a staff member undertaking night duty on their own had only less than three months experience of working in a care setting before being allocated to do night duty on their own. The staff member had not received first aid training. This meant there was a risk that if a serious incident occurred, the staff member may not have been able to react properly to protect people's health needs. The manager stated she would remove the person from night care duties and arrange for first aid training to be provided before deciding whether to allocate the person to commence night duties again.

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Is the service safe?

One staff member told us she lacked the computer skills to implement the risk assessment, of how to manage behaviour that challenge the service, to act on a person's request to use the computer. The other staff member was unable to offer this support due to the other work demands. This lack of action in delivering the activity needed meant that the risk assessment could not be followed which meant there was a risk the person could become frustrated and exhibit behaviours which were a risk to other people.

On our last inspection we found that parts of the home were unclean, therefore there was a risk of infection posed a risk to the health of people living in the home. On this inspection, although we saw improved levels of cleanliness in toilets and bathroom, we still had concerns about infection control.

A person told us, ''I did complain a lot about how dirty the bathrooms were when I came here and they have cleaned them up a bit. What disgusted me was all the toilet seats were broken when I came here. When I complain that a toilet needs cleaning, it takes ages for anyone to get around to doing the cleaning.'' This lack of action in keeping the home clean was an infection control risk.

A relative told us, ''It's a horrible place in my opinion, so dirty. When visiting a while ago we even had to clean his sink.'' Another relative said, ''I've pointed out that Dad's room isn't very clean and perhaps he needs help to do some of the cleaning, but nothing has happened. I'm also concerned about Dad's personal hygiene which I've pointed out. I visit daily, so I notice things like that.''

We inspected the premises. In toilet one, we found the toilet pan was old and stained. There was evidence of ground in dirt in corners and around mouldings. In toilet/ shower room 3, there were protruding screw heads on the toilet side of room, which people could have cut themselves on. This was reported to management and we found this had been attended to by day two of the inspection. The general appearance of these toilet areas was one of being in need of refurbishment.

There were stains on the hallway and corridor carpets on the ground floor. We saw that the outside courtyard was littered with cigarette ends and beer cans. The tables and chairs were dirty and the tables covered in cigarette burns. The makeshift ashtrays, which were biscuit tins, did not appear to have been emptied for a number of days. There was a black bin liner in the courtyard which contained empty beer cans and assorted rubbish which appeared to have been lying there for a long time. This presented as a drab environment for people. We were later informed by the provider that a ground floor bathroom was to be repaired, a first-floor toilet handle and a hole in the wall was to be repaired and plant pots were to be chosen by people living in the home.

The staff member who prepared lunch used protective clothing but people living at the home who used the kitchen to make drinks and snacks, did not exercise appropriate food handling and hygiene practice. We discussed the above with the company secretary and manager who agreed to take action to address all the areas in need of improvement we highlighted.

These issues were in breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. You can see what we have told the provider to do at the end of this report.

People told us they felt safe living in the home. A person told us, "I've been here 24 years and feel safe; it's a protected environment and I get on well with the staff ... although I do feel there could be more staff sometimes.'' Another person told us, ''I do feel safe here and have never have had any problems.'' And ''I do feel safe here, even with the other residents.''

A relative told us, "He feels very safe there and it's been his home now for twenty years. When I visit once a week he never seems to have any concerns about living there." Another relative told us, ''He does feel safe there and he does talk a lot with other residents, so he finds everyone friendly."

We looked at arrangements to ensure that people were protected from access to potentially dangerous kitchen equipment. We found secure arrangements in place to keep people safe from this risk.

On our last inspection we found a risk assessment for behaviour that challenged the service for one person which stated if the behaviour occurred, staff needed to report this to relevant agencies. We spoke with a social worker who informed us that she was satisfied that if an incident had occurred then staff would report this to her. We also spoke with a community nurse who stated that staff had reported

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issues of concern to him regarding the care of another person living in the home. This meant management had ensured that safety issues had been appropriately reported to relevant agencies.

People's care plans that we looked at contained detailed risk assessments which looked at the reasons for behaviours that challenged other people. We looked at the care plan for one person and found charts had been completed on a regular basis. Charts had been shared with people's social workers in order to try and implement changes to prevent these behaviours happening. However, we could not see from records or from what staff told us how the charts were being used to deliver change and how this would then be reviewed. This meant there was a risk that more effective methods to deal with this behaviour may have been missed. The manager said this would be followed up. One person with behaviours that challenged had a risk assessment and care plan in place. It identified the type of behaviour the person displayed and advised staff to look for triggers and to keep calm. We saw staff deal with this person's behaviour in an appropriate and calm manner.

As staff member was observed calming a person who had become agitated. They were able to calm the situation by taking the person to another part of the home to provide them with reassurance. They were able to calm the situation by taking a person to the front door to wait for his relative. Because of the staff knowledge of the situation both he and other people using the service were kept safe.

Staff described what steps they would take if someone living at the home was felt to be at risk from their environment, themselves, or from the actions of others. Staff were aware of outside agencies to contact and to report their concerns to the manager. They said the manager was available to be contacted out of working hours and they were confident the manager would act on these concerns. One staff member told us, “If I was worried about this [risk to people] I would report it to the manager.”

We looked at records of people's monies kept by the manager. We found that there were two systems of recording but that monies held by the home balanced and proper running records of transactions were kept. We checked the monies for two people and found that they were correct. This meant that staff had safely kept the money on behalf of people.

We asked staff about their understanding of people's care plans. They told us they had read people's care plans and risk assessments. This meant that they were aware of some of the issues that needed to be in place to provide safe care.

We checked three staff recruitment files. Records showed that staff worked in the home with background checks being carried out to ensure they were safe to work with the people who used the service. One reference had been received from a senior staff in a previous place of employment, rather than the manager of the service. The manager acknowledged that references should come from management to ensure they were objective in terms of a person's competence.

People told us they received their medicines. Medicines were stored in line with requirements. The temperature of the refrigerator and room where medicines were stored were checked and documented daily. We saw that a medicine audit had been completed to see whether stocks of medicines were correct and that people received their medicines. We also saw evidence of a competency test for staff so there was a safe process in place that only competent staff could supply medication to people.

We asked staff what would do if a person did not turn up to the medication room at the prescribed time to take their medication. We were told that staff would follow this up by going to the person if they were in the home, and remind them they needed to take their medicine. This helped to ensure people received their medication on time.

We saw that medicines administration records (MARs) had been completed to indicate people’s medicines had been administered to them in line with the prescription to safely protect their health needs. We looked at PRN medications. These are medicines supplied to people under specific circumstances. We did not find protocols in place agreed by the GP as to when these medications should be supplied to people. The manager said this would be followed up and put into place to ensure people’s safety in taking medicines. The provider later confirmed that medical personnel had been contacted to put protocols in place.

Requires improvement

Is the service effective?

Our findings

A relative told us, '' I go every week and food wise I think he is fine, he certainly hasn't lost any weight.''

One staff member confirmed that she had recently returned to the home after a period of leave and that she had completed mandatory training accordingly.

Staff told us that they had received training on relevant issues such as how to keep people safe, mental health awareness, and dementia. A staff member said, "I have received lots of training. I don't think I need any more."

Staff had some understanding of how best to meet people's needs. They told us they were satisfied with the training they had.

Records showed staff had induction and on-going training. They undertook a range of courses in general care and health and safety, and those specific to the service, for example some staff had received training in mental health awareness, although staff reported they had not had training in specific mental health conditions such as schizophrenia. Training was recorded on the home's training matrix. However, six staff had not yet received training in relevant issues such as first aid, infection control, dementia, and dealing with challenging behaviours. This meant there was a risk that effective care would not be provided to people to meet their needs. We spoke with the manager about this and she told us that this training would be provided.

We assessed whether the provider was ensuring that the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. The DoLS are a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted, in their best interests, to keep them safe.

When asked about MCA and DoLS we found that a staff member was working to some of the principles, such as the presumption of capacity, less restrictive practices, and maximising capacity. The other staff member was able to demonstrate some of the principles in action. We saw that an urgent request for DoLs had been made to the relevant body.

The files that were looked at contained mental capacity assessments for care and support decisions. Two out of the three files confirmed that people living at the home retained capacity for such decisions. However the two assessments had been signed as a counter-signatory rather than by the person undertaking the assessment. Hearing this the manager said it would be followed up and corrected.

Most people living at the home had their personal allowance managed by staff; however there was no evidence available to confirm whether such decisions had been agreed and consented to, as there were no mental capacity assessments for these decisions to explain the blanket management of personal funds in this way. The area manager said these issues would be looked into and rectified.

Care plans reflected specific requirements for people's nutritional needs, such as a diabetic diet, to provide effective care to people. Meal times were flexible with choices of sandwich filling and type of soup offered. The quality of meals provided depended on the culinary skills of the care staff, as the home did not employ a cook. One person told us that ' ''the food's OK'' and other people finished the food they were provided with. However, one person said, ''I prefer my own food since the food here isn't that good and they (staff) do marinade chicken and similar dishes for me, but not always. I prefer home cooked food and this place doesn't provide that.''

A person told us, ''The food is acceptable and there are always things in the fridge that I can help myself to when hungry. We are also told that we can make tea and coffee when we like, plus there are some cold drinks." Another person said, "Most of the food is okay, but at times it could be better.''

The food pantry was inspected and there was no evidence of any vegetables. There were potatoes and a large amount of tinned food. The lunch offered was tinned soup, a sandwich and some people also chose fizzy pop and crisps. The meal did not appear to offer very much nutritional value. Staff said food shopping was due to be delivered that day and that vegetables were included in this. We saw

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plentiful supplies of different types of fruit that people could help themselves to in the dining area. We saw from food records that vegetables were served although individual vegetables were not recorded so we could not see what kind of choice people had. The provider later informed us that there was a plan in place to include more fresh foods and varied menus. This will help to protect people's health needs by increasing the nutritional value of the food served to people.

We asked the manager who cooked the food as there was no designated cook. The manager said care staff would carry this out. However, there was no evidence that staff cooking abilities had been assessed. The manager said this would be carried out to ensure staff were able to cook and produce food of a high standard and that recording of food served would be more detailed in the future.

The food supplied reflected people's cultural backgrounds. For example, a person whose cultural background was from the Asian community said he had been supplied with food which respected his choices. This showed that this person's nutritional needs had been addressed.

People told us that if they needed to see a GP or other health care professionals, then staff organised this for them.

Care plans we looked at contained information about contact with other relevant agencies. One person had recently returned from hospital and the new medication prescribed by the hospital had been queried with the ward staff and doctor, as the newly prescribed medicine appeared to be incongruent with another long-standing prescription. This showed that staff had proactively made an attempt to provide effective healthcare to this person.

The same person had also had a fall recently and evidence was noted of contact with the family and social worker. Some information however was not available to follow the outcome of referrals, which meant that the effectiveness was difficult to measure.

The care plans were written in a personalised way and staff appeared to know people well. For example, one person had spent much of his life living on his own and was reluctant to engage with others. His autonomy was respected and he was not pressured to conform to the timetable of the home. One person's speech could also be difficult to understand at times. However staff listened well and they were able to readily understand what was being said.

A person was diabetic and consequently had regular appointments for chiropody. Care records showed when these appointments were due, but there was no evidence available to confirm whether or not the appointments took place. This lack of evidence meant that this it was difficult to determine whether this people's health care need were being met. The manager said this would be followed up.

Records showed that people had access to a range of health care professionals including the GP, district nurses and opticians. We saw from records that if staff had been concerned about a person's health they referred them to the appropriate health care services, and accompanied them to appointments if necessary.

People and staff told us that if they were not well then staff would take people to the GP or the 111 service would be contacted for medical advice and treatment to immediately respond to people's health needs. We saw evidence in the people's care records that staff had done this.

We looked at accident records. We found where people had medical issues, staff had contacted medical services to obtain assistance. This meant staff had responded to people's health needs.

A health care professional we spoke with told us that staff had provided effective care to a person who needed help with maintaining the person's mental health. He had pointed out that the person's continence needs had not appeared to have been effectively managed by staff in the past. Since he pointed this out, he said the person had received effective care in managing their continence needs.This demonstrated that staff had acted on the advice of a healthcare professional.

Requires improvement

Is the service caring?

Our findings

Some people appeared to enjoy living in the home. People told us: ''I have my own single room and have my own personal things there. I get myself out of bed in the morning, washed and dressed.''; ''I do get out to the shops on my own.''; ''I'm encouraged to get myself up in the morning, get washed and dress and come down to breakfast. There is a choice for breakfast. I go to bed when I want.''; ''I'm very happy here … and they look after me very well. I get up at 5.30 a.m. every morning because I like to get up at that time and I go to bed at around 8.30 p.m. This causes no problems and the staff understand my need to do this.''

Other people commented, ''I get on with everyone and I find it comfortable.'', and ''I do have physical problems in getting dressed and someone [staff] comes in to help me.''

A relative told us, ''I think they look after him quite well and he does get agitated sometimes, which the staff deal with. They (the staff) seem to be making more of an effort recently and games have appeared in the lounge, the new conservatory has been built, and this summer there was lots of refreshing drinks like lemonade.'' Another relative said, ''The staff are very flexible on choice.''

We saw that staff spoke to people in a friendly manner. We observed staff dealing calmly with a person when some behaviour became challenging. Staff appeared to be caring and motivated to provide good care to people. Some people living at the home offered to make drinks for other people who were less able. This appeared to be a positive and enabling culture.

Some people living at the home appeared to live independent solitary lifestyles and staff respected their privacy. One person said he preferred to spend time on his own and did not want to take part in any timetables of the home, and prepare his own drinks and snacks. We observed him being able to carry out this.

This told us that staff maintained people's independence and choice.

People told us staff respected their privacy and would always knock on their bedroom doors before entering. We saw examples of staff working with people in a kind and sensitive way. For example, we observed staff listening to people, speaking with them, and providing them with reassurance. These were examples of a caring attitude.

The staff we spoke with understood the importance of ensuring people could make choices about their day to day lives. One staff member told us, "People can get up and go to bed when they like. They have a choice of food and they can wear whatever they like." Another staff member commented, "People have full choice. People can go out to the shop or to the day centre if they want." These were examples of a caring attitude towards people.

A person told us that they disliked the fact that they were unable to lock the bedroom door since the lock was broken. This meant that their privacy could not be maintained. We saw evidence that the manager had e-mailed the company secretary to request that locks were fitted to people's bedroom doors that had requested this facility. The manager said she would follow this up again with the company.

There was no evidence to show that people living at the home had been directly involved in the completion of care plans by signing them, for example. This indicated people had not been involved in making decisions about their care, treatment and support. One person said, '' I know that I have a care plan, but despite asking I've yet to see it.'' This did not indicate that people had a real say about the care that they needed. The manager said this would be followed up to ensure people fully participated in planning for their care needs.

Requires improvement

Is the service responsive?

Our findings

People told us that staff understood their individual care needs. One person told us, ''The staff take me out in my wheelchair and I quite enjoy that.''

A relative told us, ''I think my Dad is getting good care and he has certainly improved his social skills since being there, for example he is talking to more people and not swearing so much.''

Another relative said, ''He really needs to get his confidence back to go outside the home. We are working towards this with the staff and social services and hopefully funding will be in place soon for one-to-one care which will enable him to go out with staff to the shops and library.''

People's cultural background had been included in care plans. This indicated that staff had the means to be able to respond effectively to people's cultural and religious preferences as they had this information.

Records showed that plans of care were reviewed on a regular basis. Staff had knowledge about people's needs. They were able to tell us who needed extra support in order to meet their needs.

During the inspection, staff actively sought feedback from people living at the home and personalised care planning was in evidence. The two staff present appeared to know people well and were able to outline choices, routines and preferences. People got out of bed at various times and subsequently arrived for breakfast and lunch at various times.

We spoke with a mental health nurse who told us that staff were aware of how to manage the behaviours of a person who was challenging to the service. There was behaviour management information for staff on how to deescalate behaviour that challenges and the staff we spoke with were aware of how to do this. We observed staff doing this in practice. This meant staff were consistent in responding to the person's needs.

People told us, ''In the summer we did go on a trip to Skegness which we all enjoyed, but I wish there was more to do. ''; ''I go out every day because I don't like being indoors and they [staff] encourage me to do that.''; ''I do enjoy music, but other than that I don't do much at all because there isn't much to do here. We do say there isn't much to do here, but not much changes.''; and ''I would like more to do here, like have a pool or table tennis table where all the residents could take part, but so far I'm not aware of any moves to buy these."

There appeared few activities on offer for people. This was another task expected to be undertaken by care staff, who, because of other work demands, were not able to provide this. Some people living at the home are younger adults, and it was not apparent that any action had been taken towards looking at employment, training or education opportunities for those people who may have been interested. Some people looked bored and one person told us, ''There's nothing to do, nowhere to go."

Staff told us there were activities such as cards, bingo, and board games. However, on the day of the inspection, no activities were provided in the home, although one person went to a local day centre and said he enjoyed this. A staff member told us that providing activities to people was erratic and depended on the willingness of staff to do this and not all staff provided this stimulation to people despite having an activities programme in place, which we saw. This had not been followed for the day the inspection. There was an activity of going to the pub for a meal once a week in this program, but this had been crossed out. The manager was surprised by this and said she would reinstate this activity.

We saw from the noticeboard that two outings had been organised this year. However, in the staff communication looked his stated that one of these outings had been cancelled. The manager said she would follow up this issue and that more activities and outings would be supplied to people. This was later also confirmed by the provider. This would then help to respond to people's needs for stimulation.

The provider's complaints procedure gave information on how people could complain about the service if they wanted to. This had included information on how to contact the local authority should a complaint not be resolved to the person's satisfaction. There was information on how people would access advocacy services if they needed support to make a complaint, though no contact details of these services. The manager said she would revise the procedure accordingly. This would then mean that people would be able to communicate their views on the service, and the service would be able to respond appropriately to any issues raised.

Requires improvement

Is the service responsive?

We looked at the complaints file. We found details of complaints made. These had been investigated although there was no evidence that the outcome of one complaint had been fed back to the complainant. The manager said this had been done in practice, but she would ensure this feedback was recorded in future.

Requires improvement

Is the service well-led?

Our findings

A relative told us, ‘’In the winter his room was cold because the radiator needed bleeding. We even ended up bringing a radiator key from home to do that because the staff didn’t have one.’’ This is not an example of proper responsive care being supplied to a person.

People told us that there had been issues in the past raised with the manager such as few activities, little activities equipment,

A person told us, “there could be a lot more communication between staff and residents in my opinion, because things such as wanting more to do get mentioned and then nothing happens.” Another person said,’’ it would be nice to have a lock on my door. I have asked, but so far nothing has happened.’’ We saw from an e-mail that the manager had acted on people's requests and e-mailed the provider about supplying bedroom locks but this had not been acted upon.

Another person said, ‘’there have been suggestions made that we need a pool or table tennis table for group activities, but so far there hasn’t been any response. Also I’d love to see some green, like potted plants in this courtyard, it’s very drab.’’ The manager showed us that a large pot had been installed into the courtyard but plants had not been supplied.

This does not give an indication that the home is always well led.

Conversations we observed between people and staff appeared limited. We did not observe staff sitting down and speaking to people at any length. Much of the verbal communication appeared to be one sentence. For example, one person said, ’’can I have a light?’’, with the staff member replying, ‘’yes, I can give you a light.'' And a staff member asking, ''are you alright?‘ with the person responding, ‘’yeah, I'm ok’’. Conversations did not go beyond this level. This may have been because staff did not have time as they had other work demands.

There were systems in place to monitor and check the quality of the service. For example, residents meetings were held to receive people's views as to the running of the service.

We looked at records for quality checks. Health and safety audit checks showed that water temperatures had been checked, and fire records showed that fire alarms and drills had taken place to keep people safe from fire hazards. However, we saw no evidence to indicate that all staff had been involved in a fire drill in the past year. The manager said this would be followed up. ‘’Building checks ‘’ were seen to be in place and we saw an e-mail from the manager to the company secretary in September 2015 requesting heaters be installed in the courtyard for people who sit there all day, and a request for a door handle to a toilet. However, there was no indication that these issues had been followed up and we saw that the door handle had not been fitted to the toilet. The manager said this would be followed up again with the provider.

We saw a ‘fault book ‘, which documented repairs that needed to be carried out. However, the end date of these repairs had not been recorded so could not be ascertained how long it took for issues to be rectified. The manager said this would be followed up.

There were also audits for relevant issues such as health and safety. However, this did not include issues we identified such as the broken toilet seat in the toilet/ shower room on the ground floor and screws sticking out by a toilet, which could cause injury to people. This had not demonstrated that management were trying to ensure the service was well led and committed to providing proper care to the people using the service.

We saw that staff questionnaires had been sent out. We found that there were comments which stated more activities were needed for people living in the home and teamwork between staff needed to be improved. However, there was no evidence these issues had been acted upon.

We did not find that other relevant issues essential for the good running of the service had been monitored. For example there were no audits for staff training, infection control, staffing levels and adherence to the Mental Capacity Act.

The general decor, furnishings and quality of the food at the home suggested a service that did not assure a high quality service for people living in the home.

These issues are a breach of Regulation 17 (1) (2) (a) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

Requires improvement

Is the service well-led?

Some people were happy with how the home was run and told us if they had an issue then staff or the manager would sort it out for them. People and their relatives told us that the level of care was seen as acceptable by most of the people living there.

There appeared to be an easy-going relationship between people living in the home and staff. A staff member told us that the manager spent time with people and chatted with them and asked them if they wanted any other foods when shopping was carried out. Staff said that the manager encouraged staff to listen to people and their concerns and try to help them.

The staff we spoke with talked spoke positively about the manager and the values of the home, stating that they felt supported and were given guidance on meeting people's needs. They felt able to raise concerns or ideas with the manager. They said that she was always available to speak with if there was a problem or concern and that she would try to follow this up and resolve it. Staff also said that they felt valued by the new manager.

Staff told us that they had received regular supervision and we saw evidence of this and regular staff meetings had been held which had discussed relevant issues such as people's care and staff training.

The manager stated that she was setting up surveys for people and staff so that the service received their views on the running of the service in order to act on any ideas they had to improve the service. The provider later sent us a survey so that people can express their views on the running of the home. Once this was carried out and action taken with regard to any views people all staff had this would then indicate a service responsive to concerns or suggestions raised.

We saw evidence that medicines had been audited to make sure people were properly supplied with their medication. There was also evidence of the auditing of care plans and risk assessments for people living in the service.

From speaking with social workers and health professionals, we saw that staff had worked with these agencies to provide proper care to people. For example, we saw that there was a ‘’social worker meetings’’ section in people's care plans. This documented communication between staff and social workers as to any relevant issues such as people's behaviour or falls and any action that needed to take place to improve care. There was also a section in care plans which documented people’s appointments with GPs and any relevant treatment that they needed. This showed us that the service was well led in following up people's health and social care concerns with relevant professionals.

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 who use services and others were not protected against the risks associated with unsafe staffing arrangements and premises because of inadequate staffing levels, inexperienced and untrained staff and insufficient maintenance of the property.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not provided with services that met their care needs because Inadequate quality assurance systems meant that people's care needs were not always met.