Four Seasons Beechcare Limited

The Peter Gidney Neurodisability Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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**

Summary of findings

Overall summary

The inspection took place on the 27 and 28 June 2016 and was unannounced.

The Peter Gidney Neurodisability Centre specialises in care for disabled adults with acquired brain injury or other complex conditions. People had a variety of complex needs including communication difficulties, physical health needs and mobility difficulties. The home can accommodate up to 26 people. The accommodation is on one level and all areas are easily accessible. All bedrooms are single occupancy and have ensuite facilities. There are two large communal lounges, a dining room, and a communal bathroom and a shower room. The accommodation is set in large grounds that people can enjoy. There were 25 people living in the home when we inspected.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The acting manager at the home is a registered manager of another of the provider's service's located directly next door. They were in the process of applying to become the registered manager of Peter Gidney Neurodisability Centre.

At the previous inspection on 29 and 30 December 2014 we made two recommendations about the meals and lack of activities for those people confined to their beds. People's choice of food had been limited. At this inspection there had been an improvement in the choices available. However there were mixed reviews from people about the food. People reported that often they did not get what they had ordered. Meal time appeared chaotic and disorganised. We have made a recommendation about this.

There had been a lack of activities available. At this inspection we found not every person living in the home had access to meaningful activities. Those that were mobile and able to communicate participated in activities such as going to the local pub but those that were confined to their beds had little or no stimulation or activities. People were at risk of social isolation.

There was a safeguarding policy in place and staff were able to talk confidently about safeguarding issues and what they would do in the event that they had any concerns. There was also a whistleblowing policy in place which the staff were aware of and how to use it if they needed to.

The provider had not responded to incidents and accidents appropriately or reported these as required. There had also been a lack of learning from these incidents to prevent the same thing happening again.

There were risk assessments in place for people, however, they lacked detail on how risks should be mitigated. Some identified risks had no strategy in place for staff to follow in order to reduce those risks occurring. Risk assessments were not being reviewed in line with the level of risk.

People had not been involved in drawing up or reviewing their care and treatment plans. The home carried out pre admission assessments but they lacked sufficient detail and did not take into account peoples likes or preferences. The plans covered peoples basic care needs but lacked any detail of specialist care needs that would support people to continue to live a full and meaningful life. Care plans were reviewed on a monthly basis but there was no evidence of how this was done or how people had been involved in any changes.

People had been supported to access some specialist healthcare professionals. However, it was unclear as to whether they had access to routine healthcare such as the GP.

The inspection identified concerns over staffing levels within the home. This was further supported by the lack of an appropriate dependency tool to determine the staffing levels required to adequately meet people's individual needs. There was also a lack of domestic staff to cover when the housekeeper went on annual leave. We have made a recommendation about this.

Infection control issues had been identified during an audit but not rectified. There were areas in the home that were not clean and some staff were not disposing of personal protective clothing appropriately.

There was an induction programme for all new staff. However not all training for staff was up to date and training for more complex needs such as epilepsy was not in place. Staff had not received supervision on a regular basis and nursing staff did not receive professional or clinical support and had to source this themselves outside of the home.

Staff understood the need to obtain consent from people and this was actively sought before any care or treatment was undertaken. However, staff did lack the knowledge of the Mental Capacity Act 2005 and how people's capacity to make certain decisions could be hampered by their health condition. The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards (DoLS) were in place for some people. However, some of the conditions attached to them the provider had not complied with. The provider had not monitored the on-going appropriateness of the DoLS.

Staff were able to tell us how they treated people with respect and dignity and we saw staff knocking on doors before entering. However, most people's doors were open all the time and we did observe some people were not fully dressed. We have made a recommendation about this.

People's records were kept in an unlocked cupboard near the front door of the home making it easy for unauthorised people to access them. We have made a recommendation about this.

There were auditing and monitoring systems in place but they were not effective or used to action things that needed to be done to improve the quality of the service people received.

Staff told us that there was an open culture in the home and that they felt listened to by the unit manager. Some staff reported communication issues between the different departments.

The acting manager and unit manager were not clear about what their individual responsibilities in the running of the home, therefore there was no clear management oversight of the home for nearly three months when the previous registered manager left. Reportable incidents were not being reported to the relevant funding authorities or CQC.

Staff knew people living in the home well and we saw staff engaging with people in a kind, compassionate and caring manner. Staff tried to encourage independence in people by enabling them to do things for themselves such as personal care.

Relatives were able to visit their relatives at any time and were encouraged to do so. There was a complaints policy in place and staff knew how to support people if they needed to complain. People had access to advocates if they needed them.#

The provider had a recruitment policy in place and recruitment practices were safe. Necessary checks were undertaken including those for qualified nurses. Their personal identification numbers (PIN) were checked against the Nursing and Midwifery Council (NMC) register to ensure they were appropriately qualified for the roles they were employed for.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not thorough and did not detail how to mitigate risks to people living in the home.

The home had not responded appropriately to incidents and accidents and no learning was taking place.

There were not enough staff to meet people's assessed needs.

Some areas of the home were not clean and appropriate guidance not being followed.

Medicines were managed safely and given as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training was not up to date and specialist training was not available. Staff were not receiving regular supervision.

Some people were subject to Deprivation of Liberty Safeguards (DoLS), however, conditions applied to these were not being met.

People received a balanced diet which met their needs. However, not everyone was happy with the choices available to them.

People were referred to specialist healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not involved in drawing up of their care plans.

Staff knew people well and were kind compassionate and caring. Peoples' privacy and dignity was being protected most of the time.

Visitors were welcomed to the home at all times.

Is the service responsive?

Requires Improvement

The service was not responsive.

The service had two activity co-ordinators but not every person had access to meaningful activities and stimulation.

Assessments of people's needs were not always completed with sufficient detail to make the care plans person centre.

There was a complaints policy in place which the provider followed and responded to.

Is the service well-led?

Requires Improvement

The service was not well-led.

Auditing systems were not effective in establishing areas that required improvement.

Staff were not aware of what the visions and values of the home were.

There was no managerial oversight of the home

Notifications were not being sent to the CQC or the local authority in a timely manner.

The Peter Gidney Neurodisability Centre

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 June 2016 and was unannounced. The inspection team consisted of two inspectors and a nurse specialist.

Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the home, which the provider is required to tell us by law. We did not request a provider information return from the provider for this inspection.

We spoke with five people and two relatives about their experience of the home. We spoke with thirteen staff including the registered manager, deputy manager, the unit manager, one senior care worker, three nurses, four care workers and a member of the cleaning team to gain their views about the home. We spoke to local authority commissioning teams about the home. We observed the care provided to people who were unable to tell us about their experiences. We asked a health and social care professional for their views of the home.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at 11 people's care files, five staff record files, the staff training programme, the staff rota and medicine records.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe in the home. One person said "I feel safe here, really comfortable." Relatives told us that they thought it was safe. "It feels like a safe and calm environment".

Care plans contained risk assessments for some risks such as pressure sores, moving and handling, falls and choking. However, the risk assessments for people living in the home were brief and did not go on to say how to mitigate the identified risks. Some risk assessments had not been properly completed. The risk assessments were designed to be completed and accompanied by a specific care plans that described the risk and how to mitigate that risk. For example, one care plan had a choking risk assessment but no care plan associated with that risk. Another care plan identified that this person was at high risk of developing pressure sores and there was no care plan associated with that risk. In each of these examples the risk assessment was not completed fully. Risk assessments had been reviewed on a monthly basis, however, each documented that there was no change.

Risks to people were not reviewed following incidents and accidents. In one case a person had been admitted to hospital following a serious incident involving equipment designed to support the person to breath. The person had been readmitted to the home but the risk assessments in relation to the incident had not been updated. One person had been involved in a choking incident on the 20 May 2016. The risk assessments in the care plan had still not been updated on 3 June 2016. The risk assessment in relation to choking recorded "no change" and made no reference to the incident. Due to the complex nature of people living in the home there were many risks which could affect people living in the home. These had not been identified or documented adequately to identify what action had been taken or how the risk would be mitigated in the future.

At the time of the inspection none of the people living in the home had pressure ulcers, however, some people had been identified as being at risk of developing pressure sores and were on pressure relieving air mattresses. We checked the settings of the mattresses to ensure that they were at the correct setting according to their care plan. We saw that four people's mattresses were not set at the correct setting for their assessed needs. This meant that even when risks had been identified the provider was not taking appropriate steps to protect people from harm or check that the plans were being followed by staff.

The deputy/acting manager had not responded to incidents and accidents in an appropriate way. There was no evidence of learning from some incidents. One person had been admitted to hospital following an incident involving equipment to support them to breath. Steps had not been taken to ensure that the incident did not reoccur. There was no clear assessed need on the care plan to give clear guidance to staff on how often they should be checking the person to ensure the equipment was functioning correctly. Nursing staff were vague about how often they should check the person. One nurse said, "when I walk up and down the corridor I always turn my head left and right and make sure I look in on people's rooms." Another nurse told us that they checked the person every two to four hours. We spoke to the acting manager and the unit manager and asked them what steps they had taken after the incident. They told us that they had not taken any steps or had a meeting with nursing staff to discuss what went wrong but that

they would organise one in the next few days.

Another incident had occurred between a member of staff and a resident. The incident had been reported to the local safeguarding team and the manager in post at the time had taken the appropriate steps. Records showed that the member of staff could be reinstated following an investigation but with certain conditions and additional training. Records showed that no one had ensured the conditions were met and the additional training required had not been completed. People were at continued risk of harm because the provider had not learnt from accidents and incidents and they had not taken appropriate steps to ensure they did not reoccur.

The provider failed to ensure that care and treatment was being provided in a safe way to people. This was a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider used an electronic dependency tools to ensure they had the correct level of staff to meet people's needs. However, when we spoke to the unit manager they told us that the dependency tool was no longer in use. Many of the 25 residents on the unit required the assistance of two staff for personal care. Throughout the two days we inspected eight people remained in bed in their rooms. Care plans did not state that this was people's preference to remain in bed. Care staff told us that they only had time to complete care tasks and that they didn't have time to talk and be with people. Nursing staff told us that it was "really hard work" for the care staff but especially if they were short of staff on a shift. The head of housekeeping told us that domestic staff were often asked to support care staff to feed people. People told us "it's a bit chaotic here in the mornings". "I definitely think there are not enough staff at night." A representative of one person said "I do feel at times they're so rushed, maybe I come at busy or bad times, but an extra pair of hands would go a long way." There was a lack of clarity from the acting manager over the use of agency staff and whether the unit had access to bank staff. The unit manager expressed concerns over the staffing levels on several occasions during the inspection and that there appeared to be a lack of understanding by senior management about the needs of people living in the home.

The lack of sufficient staffing to meet people's needs was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was not clean in all areas. The sluice was dirty and the walls were mouldy. There was an unused bathroom with mould over the walls where it had been unused for many months. Staff toilets were not clean with waste bins over flowing. Urine bottles were being left in communal toilets rather than placed in the sluice. Personal protective equipment was being disposed of in people's bins in their rooms rather than in appropriate waste disposal bins. The carpet in the lounge was stained and dirty. The manager informed us this was due to be replaced the following day. On the second day of inspection we saw that the carpet in the lounge was being replaced and maintenance workers were making repairs and the sluice was being cleaned. We spoke to the head of housekeeping about cleaning rotas and who had responsibility for infection control and hygiene. They told us that there was one domestic cleaner for the unit and that they supported them with cleaning duties. The house keeper had not been in work for the previous three weeks so the domestic staff had struggled to complete all the cleaning tasks. We looked at daily cleaning records. These were not accurate records of what was cleaned on a daily basis as they were not consistently completed and had gaps where nothing was recorded.

We recommend the provider ensures there are adequate domestic staff at all times and all staff follow the DoH Infection control guidance for care homes.

There was a safeguarding policy in place for the home which sign posted staff to local safeguarding protocols; however, there was not a copy of the Local Authorities Safeguarding policy and protocol. The safeguarding policy did provide full details on how to make a safeguarding referral. Staff were able to identify the different types of abuse and able to describe what they needed to do in the event of any concerns. Most staff had completed training in safeguarding vulnerable people. The home had a whistle blowing policy in place and staff told us that there was a staff hand book which detailed the policy and the phone number to call in the event that they needed to use it. Staff said they would have no concerns in using the whistleblowing policy if they had to. Staff were aware of their obligations in keeping people safe and what to do in the event abuse should take place, but also prevent abuse from happening.

The provider had a recruitment policy in place and the acting manager was following this. Interviews were carried out and references were gathered. Staff had been vetted before they started working at the home through the Disclosure and Barring Service (DBS) and we saw evidence of this on staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Gaps in employment history had been explored in all staff files we looked at apart from one. Other files we looked at specifically asked and explored reasons for gaps in employment history. Qualified nurses personal identification numbers (PIN) were checked against the Nursing and Midwifery register to ensure they were suitably qualified to work with people living in the home. The provider was following safe recruitment policies and guidance when employing new staff to the home.

The home had environmental risk assessments in place which were regularly reviewed and updated. There were up to date electrical and gas certificates in place. There was a legionella risk assessment in place and checks were carried out on a weekly basis throughout the home. People had personal evacuation plans in place which detailed how to support people to leave the building in the event of an emergency. Staff told us that the home carried out regular fire drills and the fire alarm was tested regularly. People were protected from potential environmental risks.

Staff had a good understanding of the medicines systems in place and there was a policy in place to guide staff from the point of ordering, administering, storing and disposal and we observed this was followed by the staff. There were appropriate arrangements in place in relation to obtaining medicines. We observed an effective system for their storage and monthly ordering to ensure that prescribed medicines would be available for people at all times. A number of checks and an audit were conducted on a weekly basis. These ensured medicines were ordered and no excess stock was kept by the home. The manager demonstrated they had an effective governance system in place to ensure medicines were managed and handled safely.

People were protected from the risks associated with the management of medicines. People were given their medicines by trained staff who ensured they were administered on time and as prescribed. The unit manager was trained to administer medicines along with being able to assess and support the nursing and care staff.

Requires Improvement

Is the service effective?

Our findings

People were positive about the care they received and the way they were looked after. "I'm very well looked after here." Relatives told us "I couldn't wish for anything better." People were less positive about the food provided at the home.

Staff had been through a thorough recruitment process and had completed an induction programme. Training records showed that staff had completed mandatory training via e-learning, but that not everyone had completed all the training required to care for people effectively. People living in the home had various complex health issues such as epilepsy or needed to be supported with breathing or feeding. Staff were unsure about what training they had received. We asked if staff had received training in caring for people with a tracheostomy. Nursing staff were unable to tell us if they had received training in this area despite records confirming that this had taken place six months previously. Staff had not received training in supporting people with epilepsy. Staff were not up to date with mandatory training and had not received additional training in order to support the needs of people living in the home. There was limited evidence of individualisation within the service with staff not being given the training to support people and provide high quality care. This meant that people might be at risk of not receiving the appropriate care and treatment to improve their outcomes.

Staff had not received supervision on a regular basis. Since the start of 2016 supervision was provided by the unit manager. However only 16 out of 28 staff had received any form of supervision. Nursing staff told us that they did not think they received adequate professional or peer support and that they had to source this from outside of the work place. They had not been given any support or training towards the revalidation of their nursing registration. "We are just given a folder to use for revalidation". Another member of staff told us "we are supported by the unit manager; however they are not a clinical lead." On the second day of our inspection the acting manager told us that one of the nurses had been promoted to Clinical Lead for the unit.

The provider failed to provide adequate training and supervision to the staff to enable them to adequately support people living in the home. This is a breach of Regulation 18 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training in the Mental Capacity Act 2005, however, the nurses we spoke to had limited understanding of the Act and how to apply it in the setting within which they worked. The Act provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care plans showed that people's capacity had been taken into consideration with capacity assessments in place where appropriate. However, not all assessments were decision specific. For example one assessment read that the person was unable to give consent to all aspects of care, personal hygiene, medication and placement. An assessment had not been completed for each decision that needed to be made. It could be that the person was able to

make decisions about some things and not about others. Where assessments were not being carried out in line with the Act this meant that people could have decisions made on their behalf that were not in line with their choice or wishes.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Several people living in the home had a DoLS in place. However, when we looked at conditions of some of the DoLS we found that these were not being adhered to. For example, one condition stated that the restriction should be monitored every three months and a report sent to the authorising body, the family were given updates and the home was to try and establish some life history for the person. There was no documentation to state this had been done since the authorisation was put into place. Another authorisation for a DoLS had expired and an extension had not been applied for. The unit manager told us that there was no system in place to monitor DoLS to ensure compliance with their conditions or ensuring they were reapplied for when they expired. This meant that people could be deprived of their liberty or restricted unnecessarily.

The failure to review and follow up on DoLS conditions may result in unlawful restriction of people. This was a breach of Regulation13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gained peoples consent before giving care and treatment. Some people were not able to give verbal consent. We asked staff how they ensured people gave consent and they told us that they knew signs people made. For example, people might put their thumb up in agreement. The interaction we saw between staff and people was warm although at times it was brief. Care plans showed that consent to care and treatment had been considered.

There was no clear documented evidence in people's care plans that people had routine access to health care professionals. There were no records of visits by GP's or external healthcare professionals. However, there were records of visits by a chiropodist. Staff had made referrals to outside agencies such as Speech and Language Therapists (SALT) and care plans showed that one person had been visited by a Multiple Sclerosis (MS) specialist nurse. Some people had Do Not Attempt to Resuscitate (DNRCPR) in place in their care plans. Most of these had been completed in different care settings but they had not been reviewed when people were admitted into the home. Staff had not made contact with health care professionals in order to carry out reviews of the DNARCPRs. We spoke to nursing staff about the DNARCPRs but they were unaware that they required reviewing and updating. One member of staff could not tell us if the DNARCPR's in place were current or whether they would attempt to resuscitate people with the current documentation in place.

People maybe at risk or receiving inappropriate care and treatment. This is a breach of Regulation 9 (1) (a) (b) (c) (3)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were supported to maintain a healthy and nutritious diet. People's weights were recorded in care plans and staff used a nutritional assessment tool such as MUST to establish if people were at risk of malnutrition. The food was cooked off site due to a lack of a suitable kitchen on the premises. The food was stored and prepared at the neighbouring care home then transported using insulated boxes. The food's temperature was checked at each stage of the process. The chef and kitchen assistant told us that some people were on a soft diet. The chef was aware of who was on a soft diet and there was a list on the wall in the kitchenette area where the food was served from.

Some people told us that the food was good and met with their expectations; other people said it did not.

One person told us "the food is lovely; you get to choose every day for the next day. If I change my mind they're ok. There is always enough food and there are drinks all day." Another people told us "the food is either rubbish or alright." "On Saturday we had burgers and I asked for a cheese burger. I was really looking forward it, but it came with no cheese. Sunday we had spring rolls, they were alright." Staff were unsure if people had been involved in designing or choosing the menu. We spoke with the chef who said that he had sought feedback from management meetings on what people would like to eat. They were surprised to hear negative feedback about the food and on the second day of inspection arranged a meeting with people to discuss the menus.

We observed meals being served and eaten at lunch time in the dining area. There were no menus on display to guide people as to what was on the menu. The staff were not aware of what was for lunch that day when we asked them earlier in the morning. Where staff sat with people we observed good practice with people being supported to eat, laughter was heard and interactions were positive. However, for one person we saw they sat alone, no staff went to sit with them and they had to wait until appropriate cutlery was provided before they could eat their dessert. Staff were seen to be congregating round the door of the kitchen talking to each other which gave a noticeable feeling of lack of organisation.

We recommend the provider consults with residents about menu choices and that the dining experience is improved.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were caring. Relative said "they are very kind. It's the little gestures. The other day one of the men picked roses from the garden for all the ladies." Another relative told us "the staff are here because they are dedicated."

Long standing members of staff knew people well and we observed staff having meaningful conversations and interactions with people. For example, we heard staff encouraging one person with his mobility and walking, and another talking about their favourite colour and that their bedroom had been painted lilac. Staff were seen to be kind, compassionate and caring towards people.

People had not been involved in drawing up of their care plans. Only one care plan out of 11 that we viewed made reference to the person being involved in the drawing up of their plan. The notes said that the care plan had been discussed with the person but they were unable to sign it.
There were no communication or hospital passports for people. For example a hospital passport would enable people that were admitted to hospital to be effectively cared for by staff in a different environment. The passports would go with them to hospital and give staff important information on how to communicate with people and how to best work and support them in a stressful situation.

The home had a corporate brochure available to people living in the home. This let people know what they could expect from living in a home run by the provider. This was not in a format suitable for many of the people living in the home such as easy read, braille or audio. The home was lacking in terms of pictorial language and symbols. These could aid understanding and engagement of those who lived at the home. No other documentation, such as care plans, were available in other formats that might be more suitable for people living in the home. This meant that some people might not be able to understand the care and treatment being offered to them.

Where people not being involved with the drawing up and reviewing of care plans this was a breach of Regulation 9 (3) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A lack of information in formats suitable for people to enable them to understand the care and treatment to be received was a breach of Regulation 9 (3) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to tell us how they would provide care with privacy and dignity. How they would ensure that doors were closed, people were covered up and that they would tell them what they were about to do when providing personal care. Staff were observed knocking on people's doors before entering and speaking to people in a dignified manner. During the course of the inspection we noted that every person's door was open unless personal care was being given. Some people were not fully dressed and their dignity was not being preserved.

We recommend that the provider ensures that people's dignity and privacy is preserved at all times.

Staff were able to tell us about the importance of keeping personal information confidential. They told us that they would not have private discussions about or with people in public areas and that certain conversations would only be had with those authorised and on a need to know basis. Staff records were kept in a lock cupboard; however, care plans were kept in cupboard by the nurses' station by the front door. This was not locked and could easily be accessed by staff and visitors in the home.

We recommend that the provider ensures people's care records are kept confidentially and secure at all times.

Staff told us that they tried to ensure that people remained as independent as possible. They told us that they supported people to wash themselves where they could. We saw one person walking up and down the corridor of the home. Staff told us that they were trying to maintain and improve their mobility. The unit manager told us that the home used to have access to a physiotherapist to support people, but the provider no longer supported this service. They told us that they tried to access physiotherapy for people from the NHS but this was proving difficult.

There was information about how to access advocates if people needed additional support. We were unable to see written evidence that people had used advocates but were told one person had recently been support by one.

Some relatives of people living in the home visited often and told us that there were no restrictions on when they could visit. People were actively encouraged to maintain relationships with their relatives.

Requires Improvement

Is the service responsive?

Our findings

Some people told us that the home was responsive "I haven't found one person that isn't helpful." Other people were less positive and told us "We do have resident meetings, but I would say, if I made a suggestion, I wouldn't feel listened to."

The home carried out pre admission assessments on people's needs however; the information on these assessments was minimal. None of the assessments we looked at had any information on what people's likes and dislikes were and there was no life history about people prior to admission to the home. The care plans were not person centred and focused solely on their medical needs of people and the tasks required to meet that particular need. Therefore there may have been a lack of information to make a decision as to whether the service could meet all a person's individual needs.

The provider was failing to take into account peoples choices and individual preferences when establishing and drawing up their care plans. This is a breach of Regulation 9 (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For people that were mobile and able to communicate there were meaningful activities taking place, such as trips out shopping, playing mini golf and going to the local pub. At the home people were able to participate in cooking, singing sessions and taking part in quizzes. The home had two activities coordinators to support people with these activities. Some people told us "'It's a bit chaotic here in the mornings and I think that's why there isn't much on activity wise, but the new activity coordinator is as good as gold and would do anything for us." "Yesterday the activities coordinator took us down the pub which was nice. It was nice to get out of here for five minutes." We asked the activities staff what activities were available, "A lot of the activities depend on the weather or how many people get up that day. Although we have a time table in situ which helps gives an overview for the residents, its very flexible as to what they want to do on that day. For example, today we were going to play bowling, but not enough people got up, so we've decided to sit outside as its lovely and have a quiz."

At the previous inspection in December 2014 we recommended that the service increased the activities for people confined to their bed. During a meeting following the last inspection staff were told "the sensory area wasn't being used half as much as it should be, these patients need to come out of their rooms every now and then." At this inspection we saw little evidence that there were any meaningful activities or engagement provided for these people. People were still being placed at risk of social isolation. We looked at four people's activity logs and saw that there was usually one activity recorded on a weekly basis. For one person, between the 29 March 2016 and 27 June their recorded activities included, being read to, being made hot chocolate and talking about what was on TV, and having a hand massage and nails painted. Another person had received a post card and their weekly activity had been to talk about that post card. Another person had enjoyed a cup of tea and talking about family. On one occasion they had been taken out of their room on the sensory bed and had played Ludo in the lounge. This meant that people were at risk of social isolation through a lack of stimulation.

Failure to provide activities and stimulation for people in order to meet their individual needs was a breach of Regulation 9 (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us that they were able to make choices about things such as the décor of their bedroom and we saw that some people's bedrooms were personalised with their own possessions. For other people without the support of relatives, bedrooms were sparse and had not been personalised. People told us that for example, "I make my own choices about what I want to " but so far I've not had to make any major decisions. "

People and their relatives completed surveys and feedback was positive about the care they received from the staff. The provider also held residents and relatives meetings to gain additional feedback from people. Minutes from a relatives and residents meeting held on the 8 June 2016 detailed one relative asking if the bath had been repaired. The acting manager confirmed that it had not, but offered the use of a bath in the home next door if people preferred a bath. Until this point people only had access to the shower to wash. Staff confirmed that the bath had been out of action for the previous 18 months. On the day of inspection the bath was still not working and the unit manager and acting manager confirmed that neither of them had followed this up. On the second day of inspection it was confirmed that a part had been ordered and the bath would be repaired soon. This meant that the provider did not actively act on feedback from people or their relatives to make improvements.

We recommend that the provider reviews how it responds to feedback from people and their relatives to make service improvements.

The provider had a complaints policy in place and details of how people could make a complaint was given in the corporate guide for people. This gave clear details of what people needed to do, the details required and what people could expect in terms of responses and time scales. The policy also gave the details of the local authority, Care Quality Commission and Local Government Ombudsman. We looked at the complaints log and saw that the provider responded in accordance with their policy. The provider responded appropriately to complaints made to them.

Requires Improvement

Is the service well-led?

Our findings

People told us they thought the home was well led. "The unit manager is as good as gold, they've been here forever." Relatives told us they thought the home was well led. "I see things are done, like the maintenance, so it suggests it is being well run."

There was no registered manager in post at the time of inspection but the registered manager of the home next door was overseeing both homes with a view to becoming the registered manager for both homes. There was a deputy manager covering both homes but they had only been in post one week and they worked from the home next door throughout the duration of the inspection. The home also had a "unit manager" who had been promoted when the previous manager had left in April 2016. This person had worked in the home for many years but did not have clinical qualifications. Overall responsibility for the home was with the acting manager.

The provider had a system of quality assurance and auditing in place to monitor the overall quality of the service and identify the need for improvements. However, these audits were not always effective. For example, infection control audits had identified shortfalls but did not result in an action plan to prevent reoccurrence in the future. A health and safety audit had been completed on the 25 May 2016. This asked if current monthly maintenance checks had been completed and had been answered yes. However, there was one bathroom in the home where the specially adapted bath had been out of order for 18 months. Although this had been reported as needing repair no one had followed this up to ensure appropriate action was taken in a timely way.

Audits did not pick up issues of correctly recording care and treatment for people. Care plans included daily care charts where people's care and treatment was recorded. These daily care charts were not always accurately completed or completed at all. For example, one person's care plan stated that they required turning every four hours. On the 26 June the care chart recorded care interventions at 00:25 hours, 05:10 hours, 07:45 hours and 14:20 hours. The next recorded care intervention recorded was at 04:20 hours on the 27 June. Daily care charts for the 9, 10, 11, 12, 13 and 14 June also reflected that this person was not turned in accordance with their assessed need of four hourly turns. We spoke to staff who told us that care had been given and that it should have been recorded on the care charts. Another person was unable to ask for food and fluid and their care plan stated they should be offered a drink every two to three hours. Daily care charts did not record that drinks were being offered or taken. This meant that provider could not be sure that people had received treatment according to their assessed needs.

The provider had failed to ensure a robust auditing system was in place and to maintain accurate and contemporaneous records of people's care and treatment. This was a breach of Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to the acting manager about their responsibilities. They told us that this was "to manage a safe home with a strong team. To empower staff to take control, to keep to budgets, and to keep beds filled but to manage people's needs." They were also aware of their reporting responsibilities to the CQC and other

agencies. However, incidents that should have been reported as an incident or accident were not being reported. For example a choking incident that occurred on the 20 May 2016 had not been reported to the CQC or the funding authority. Some people had authorised Deprivation of Liberty Safeguards in place but the CQC had not been notified of these.

The provider was failing in their legal duties to notify the appropriate authorises or CQC of any significant events that could have an impact on peoples care and treatment. This was a breach of Regulation 18 (Registration) Regulations 2009.

Staff told us that there was an open culture and that the unit manager was approachable. "They are firm but fair, they get things done." Staff talked about working as a team however, some staff reported that communication was not always clear between departments. Staff meetings had not been held since September 2015, however, we saw that a nurses meeting had been held in March 2016 where the issue of staff handover and communication had been raised.We asked staff about the visions and values of the home. We were told different things by different staff, with some staff not being able to tell us what the visions and values were.

When we spoke to both the acting manager and the unit manager there was no clear understanding of who was taking responsibility for what action. For example, when we asked who was responsible for the line management of one member of staff the acting manager said they were unsure. The unit manager reported that they unsure of what their responsibilities were, and, had they known, for example, that they should have been monitoring the DoLS authorisation, then they would have done so. We then spoke to the regional manager who advised us that they were having a meeting with senior management staff to establish roles and responsibilities. This meant that there was no adequate oversight of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The home was not notifying CQC or the funding authorities of significant events. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not involved in the drawing up of their own care plans. People's likes and dislikes were not taken into account. There was a lack of meaningful activities for some people. Regulation 9 (3) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always identified and did not detail how risks could be mitigated. There was no learning from accidents and incidents and no steps were taken to ensure incidents did not happen again. People may be be at risk of inappropriate care and treatment due to inadequate guidance for

	the staff to follow. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were being deprived of their liberty as the conditions attached to these were not being met, reviewed or renewed as needed. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality Assurance tools and processes were ineffective and not acted upon. There was a failure to maintain accurate records of people's care. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was a lack of suitably qualified, experienced and skilled staff to meet people's needs. Staff were not receiving adequate training, support and supervision. Regulation 18 (1) (2) (a) (b)