Kingsthorpe Care Limited

Boughton Lodge Care Home

Inspection report

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Date of inspection visit:
21 April 2016

Date of publication:
13 June 2016

Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

We carried out this inspection on 21 April 2016.

Boughton Lodge Care Home is situated in Kinsgthorpe, near Northampton. It is registered to provide accommodation and personal care for up to 19 older people, who may be living with dementia. At the time of our inspection there were 18 people living at the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 registered manager had resigned from the service and was working their notice period. They were aware of their obligation to apply to the CQC to de-register. The provider had started the process of recruiting a new manager, who would register with the CQC once in post.

There were insufficient quality assurance systems in place at the service. The provider failed to complete checks and audits on a regular basis or use them to identify areas of development. Incidents and accidents had not been reviewed and action had not been taken as a result to manage future risks to people. Incidents

of potential abuse or improper treatment had not been recognised as such and therefore had not been reported to appropriate external bodies.

Risk assessments were in place; however these were not reviewed regularly to ensure that the latest risks to people and the service were considered. Where risks had been identified, the risk level did not match what was recorded in people's care plans; therefore staff did not have the correct control measures or information available, to help them manage risks to people. Medication was not managed effectively. Staffing levels were not always sufficient to meet people's needs; however staff had been recruited following safe and robust procedures. Medication storage was not always secure and medication records were not complete. Stock levels of medication were not always recorded and were not checked regularly to ensure that they were correct.

People's consent to their care, support and treatment had not been sought and documented. Where people lacked the mental capacity to make their own decisions, the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards had not been adhered to.

Members of staff had not received regular training support and supervision to enable them to perform their roles and identify areas for them to develop their skills and knowledge.

Care plans did not show that people had been involved in planning or reviewing their care. These plans were not presented in a person-centred way and did not show that people's views and preferences had been taken into account.

People had enough to eat and drink to have a balanced and nutritious diet and referrals were made to appropriate healthcare professionals for support with this if necessary. People had access to other healthcare professionals, such as GP's or district nurses, if needed and could see them within the service or in a community based setting, such as a local GP practice.

There were positive relationships between people and staff. People were relaxed and happy at the service and felt comfortable with the staff caring for them. Staff treated people with respect and dignity and welcomed the visits of people's family members or friends. If people were unhappy with their care, there was a system in place to receive, log and act on any complaints that were made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks had not been appropriately assessed and steps to mitigate risks had not been taken.

Incidents of potential harm or improper treatment had not been reported or investigated to ensure that people were safe from abuse.

Systems for the management and administration of medication were not always effective.

Staffing levels were not always sufficient to meet people's needs. There were robust procedures in place to ensure that staff were of suitable character to work at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's consent was not always sought. Where people were unable to make their own decisions, the principles of the Mental Capacity Act 2005 had not been applied.

Staff members did not receive regular training and supervision to ensure they had the skills, knowledge and support they needed to perform their roles.

People had enough to eat and drink to ensure they had a balanced and nutritious diet.

People were supported to see healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their family members had not been involved in planning their care.

Staff treated people with kindness and compassion and had developed strong relationships with them.

People were treated with dignity and respect and their privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive person-centred care. Staff were aware of people's individual needs and wishes, however care plans did not provide them with specific personalised information about people's care and support needs.

People were supported to take part in activities of their choosing.

There were systems in place to receive and act on complaints from people or their family members.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance processes were not robust. Checks and audits were not carried out regularly and failed to identify areas for development within the service.

People and staff did not have regular access to the registered manager.

There was a positive and open culture at the service.

Boughton Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 21 April 2016 and was unannounced. It was carried out by one inspector and an Expert-by-Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert used for this inspection had expertise in caring for someone who used this type of service.

Prior to the inspection we checked the information we held about the service and the provider, such as statutory notifications. A statutory notification is information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. In addition, we asked for feedback from the local authority who has a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service. We spoke with 13 people living at the service, as well as three of their visitors. We also carried out observations of people's care throughout the day, including at key times, such as meal times and when medication was given. We spoke with the provider and two senior member of staff as well as four members of care staff, the cook and the housekeeper.

We looked at care records for six people, as well as six people's Medication Administration Record (MAR) charts to ensure they were reflective of their needs. We also reviewed five staff recruitment files as well as other documents and records relating to the management of the service, such as staff rotas, audits and

meeting minutes.

Inadequate

Is the service safe?

Our findings

There were not effective systems in place to manage risks at the service. Staff members told us that there had been a recent re-structure at the service which would mean that, once fully implemented, senior staff would be responsible for the regular review and update of care plans and risk assessments for people. They told us that prior to this the registered manager had been responsible for reviewing all documentation, including risk assessments.

We looked in people's care plans and found that risk assessments were in place; however they had not been reviewed on a regular basis. Planned monthly reviews of risk assessments had not taken place, which meant that staff were unable to assure us that the content of risk assessments were accurate and provided them with the information they needed. For example, we saw that a number of care plans and risk assessments had not been reviewed since January 2016. We also found that care plans were not updated to reflect changes to assessed levels of risk. We found that three people had tissue viability care plans in place which stated they were each at medium risk of skin integrity breakdowns. The associated Waterlow tool (used to assess the risk level) gave a high rating for each person; this meant that care plans were not updated to reflect the current risks people were presented with. This in turn meant that there was not effective control measures detailed for staff to follow to help reduce the risk or the impact of any potential harm that people may come to.

We also found that risk assessments did not always provide staff with detailed control measures, informing them of the best course of action to minimise the impact of risks to people. For example, the service had carried out a mental health risk assessment for people; however there were no care plans or control measures associated with this for any identified risk level, including high. This meant that staff were not provided with the information and guidance to keep people safe from potential harm.

We spoke with the provider about the risk assessments we found. We showed them that they had not been updated regularly and failed to provide staff with control measures to help reduce the levels of risk. They told us that they agreed with the points that we raised and would implement steps to improve the management of risk within the service. We also spoke to them about general risk assessments for the service, environment and visitors. We reviewed these assessments together and found that they also had not been reviewed on a regular basis and failed to provide guidance on how to manage risk at the service.

Risks to people had not been assessed regularly or robustly. Sufficient steps and control measures were not in place to mitigate risks and reduce the likelihood of people suffering harm. This was a breach of regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always safeguarded against potential abuse or improper treatment. We checked records regarding accidents and indents that had occurred at the service and found that since the start of January 2016, there had been 11 incidents which included unwitnessed falls and unexplained bruises as well as one incident of physical aggression from one person to another. There were no records to show that these incidents had been reported to the local authority safeguarding team or the Care Quality Commission (CQC).

After the inspection we spoke with the local authority safeguarding team, who confirmed that they had not been notified of any of these incidents. This meant that external authorities were not aware of these incidents and were therefore unable to carry out an independent investigation into them.

Staff members explained to us that the reporting process for incidents involved them completing incident forms and carrying out observations afterwards to monitor people for any ill-effects. They also told us that they were aware of their responsibilities in terms of safeguarding, however had not identified these incidents as potential abuse. One staff member told us, "Everybody has a responsibility to report to safeguarding." The provider told us that they were not aware of these incidents being reported externally but agreed that the incidents we showed them should have been.

People were not protected from abuse or improper treatment as systems and processes were not established and operated effectively. Incidents of potential abuse were not identified by the service, therefore were not reported to appropriate external bodies. This was a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us that they felt safe at the service, and that staff worked to keep them comfortable and protected from harm. We asked one person how safe they felt, they told us, "Oh very safe. I'm very comfortable here." Another person said, "I like it here, I do feel safe."

Medication was not managed safely. We spoke with staff about the systems in place for medication administration. They showed us that medication was administered in accordance with people's Medication Administration Record (MAR) charts. These provided staff with details regarding what medication to give people and at what time and staff signed them to state that they had administered the prescribed dose.

We checked MAR charts and found that there were some gaps on them where staff had not signed to record that medication had been given. In addition, the stock levels of medication received and carried forward by the service had not been recorded for each medication. Neither was it possible to count the stock levels of these medications and ensure they were accurate. This meant that it was not possible to determine whether or not people had received their prescribed medication appropriately. In addition, MAR charts did not have a photograph of each person on their profile sheet. This meant that new or agency staff would not be able to confirm that they had provided the right person with the right medication, if that person was unable to confirm their own identity.

Medication was not stored appropriately. We found that current medication was stored in a locked trolley. In accordance with best practice guidance, the provider had also locked this trolley to a bracket on the wall, so that it could not be moved however; if the trolley was moved the bracket came away from the wall, allowing the trolley to be wheeled away. When we raised this with the provider they took action to resolve this concern.

The service had a system in place to record the temperature that medication was stored at, which should be completed on a daily basis. We saw that this was not carried out every day, which meant the provider was unable to show that medication was always stored at the correct temperature. In addition, we found that controlled drugs were stored in a separate locked cupboard, which was located in the kitchen. There were no systems in place to record the storage temperature of controlled drugs.

The provider had implemented a monthly medication audit; however this had not been completed in full since August 2015. The audits that had been completed failed to compare actual stocks of medication with the information on MAR charts, to ensure that both totals matched. They had also failed to identify or

investigate missed signatures on MAR charts, as well as concerns regarding the storage of medication.

People told us that they were happy with the way the service managed their medication. They told us that members of staff made sure they got their medicine at the right time and in the right dose. One person said, "Oh yes, they give me my tablets when I'm supposed to have them." Another person explained that they had been suffering from a headache that day and that staff had made sure they received pain relief to help.

Staff members told us that they were aware of people's specific wishes regarding medication administration. They talked us through the different ways that different people liked to take their medicines and the different drinks they liked to take them with. We observed staff administering medication and saw that they ensured they gave the correct medication at the correct time, in line with people's individual wishes.

The service did not have sufficient systems and processes in place for the proper and safe management of medicines. This was a breach of Regulation 12 (1) (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their families told us that staffing levels were sufficient to meet their needs. One person said, "Yes I think there are enough staff." A family member said, "There seems to be enough when I am here."

We received mixed feedback from members of staff regarding staffing levels. One member of staff told us, "Staffing levels are good." Other staff were not as positive and told us that, at times, staffing levels were low, which meant they had to rush between tasks to ensure people's needs were being met. One staff member said, "Staff sickness problems are a real problem." Following our inspection two members of staff got in touch with the CQC to share their experience of working at the service. They also told us that there were problems with staffing levels and that in the days that followed our inspection, staffing levels were low due to staff absence.

Staff members also told us that the service regularly used agency staff to cover absence. They told us that where possible, they used agency staff that were familiar with the service to help maintain continuity of care. During the inspection we saw that staffing levels matched the duty rota and that there was enough staff available to meet people's needs. We spoke with the provider about staffing. They told us that they were in the process of recruiting new staff to help improve staff continuity. We asked them how staffing levels had been set and they explained that there was a needs analysis tool available to them; however this had not been used recently to assess people's needs and ensure that staffing levels were correct.

Staff members told us that, prior to their employment at the service; they had to supply the provider with an application form which included their employment history and references. They also told us that the service carried out a Disclosure and Barring Service (DBS) criminal records check before they could start work, to ensure they were of good character. One staff member told us, "Yes I had to do by DBS and references before I could start." We looked at staff files and saw that the provider had carried out suitable and robust checks to ensure that staff were of suitable character to perform their roles.

Requires Improvement

Is the service effective?

Our findings

People's consent to their care had not been sought or documented in their care plans. We found that people had a number of different care plans in their files, each of which had a section for people and their family members to sign, to demonstrate that they had consented to the content of that care plan. None of the plans that we reviewed had been signed by people or their family members. This meant that the service was unable to demonstrate that they had sought people's consent when planning their care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff members told us that they did not carry out regular mental capacity assessments; however they were aware of people's wishes and made sure they were respected when they provided them with care. Members of staff were unsure whether or not people living at the service had a DoLS authorisation in place. When we spoke with the provider about this, they were also unsure.

There were no systems in place to ensure people who lacked mental capacity were supported to make their own decisions, in accordance with the principles of the MCA. For example, we saw that one person had a mental capacity care plan in place. This stated that the person had been assessed as lacking capacity, however it did not state the specific decision they lacked the mental capacity to make. In addition, at this person's previous care setting they had a DoLS authorisation in place. The service had not made an application under DoLS, or carried out an assessment of their capacity to agree to their current care placement. This meant that people who did not have the capacity to agree to their care, treatment and support were at risk of having their liberty deprived without following the principles of the MCA and DoLS.

The service had failed to ensure that they had sought people's consent when writing their care plans. Where people lacked mental capacity to agree to their care, they had not carried out suitable assessments of their capacity, in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 (1) (2) (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff members did not receive sufficient training and support to ensure that they had the skills and knowledge that they needed to perform their roles. Staff members did not receive regular supervision sessions to discuss concerns they may have, or to raise any performance or development issues. One staff member told us, "I haven't had any supervisions yet." Another confirmed that they had not received a formal supervision, despite only having started at the service within the past six months. They explained that they

had not received guidance and support in their role from the registered manager and had not discussed their performance or any areas which may need to be developed.

Staff files confirmed that staff had not received supervision sessions with senior staff. We saw that there was a template in place to record supervisions, and each staff member had a supervision tracker to record meetings throughout the year; however neither of these documents had been completed. The provider told us that they expected staff to receive monthly supervision, however acknowledged that this had not happened when we showed them the lack of documentation regarding this.

Staff received an induction as when they started working at the service. This included an orientation to the service and shadowed shifts, which allowed them to get to know people and their roles. Staff told us that they did not receive any specific training during their induction period, and that they were not aware of any planned training coming up. The provider showed us that the induction had been updated to reflect the requirements of the Care Certificate. This meant that new staff members would be enrolled on the Care Certificate, to help them ensure they had the skills and knowledge that they needed.

The provider confirmed that staff did not always receive training courses when they employed new staff. They explained that they employed experienced staff who had completed training with their previous employment, however did state that they planned to make key training courses, such as safeguarding and manual handling, part of the staff induction. In addition, they showed us that staff had access to a library of online training courses, which they used to refresh and update their skills. Records showed that staff had completed these courses; however the staff training matrix had not been updated and did not reflect the most recent training which had been completed. There were no records to demonstrate that staff training needs had been analysed, or that future training courses had been scheduled to meet those needs.

Staff members did not receive regular support, supervision and training. This meant that staff were not able to develop the skills that they required to provide people with care and support and relied upon knowledge gained from previous employment. In addition, should staff members lack this knowledge, there were not systems in place for them to gain it. The lack of monitoring of staff performance meant that areas of poor performance were not identified and action was not taken to manage this. People have been exposed to poor care, treatment or support as staff members lacked the training, support and supervision to help ensure they had the skills, knowledge and support they needed to perform their roles.

Members of staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were happy with the food they received at the service. They told us that they felt meals were nutritious and tasty, and that there was plenty of choice, including what they ate and where they had it. We asked one person if they had a choice of meals, they told us, "Oh yes, I can have what I want." Another person said, "I like to have my breakfast in my room but staff are very good. They would take me downstairs but it's my choice." People also told us that the quality of the food was good. One person said, "Oh, yes, I have this sometimes or something else what I fancy. She's very good the cook." Visitors were also positive about people's meals.

We observed breakfast and lunch being served. We saw that people were given their choice of meals and kitchen staff were prepared to make people an alternative meal if they didn't want one of the options. Meals were appetising and served in a relaxed and comfortable atmosphere. If people needed support with eating,

staff did this in a supportive and patient manner, to ensure that people were not rushed and able to enjoy their meals. People also were given drinks and snacks throughout the day. We also saw that there were documents available to record people's nutritional intake, if such monitoring was needed.

People were able to access the services of a number of different healthcare professionals if necessary. People told us that staff would help them to get an appointment if necessary and that healthcare professionals such as GP's and district nurses came to see them at the service. One person said, "They're good. I had a water infection some time ago. They got me to see a doctor the next day." Staff confirmed that people were supported to book healthcare appointments and staff would go with them to the appointment if they wanted them to. We saw records of healthcare appointments in people's notes, including the outcome of these appointments and any additional instructions which staff had to take on board.

Requires Improvement

Is the service caring?

Our findings

People were not involved in planning their care or support. None of the people we spoke with, or their family members, were aware of their care plans or the contents of them. We asked one person if they knew that they had a care plan and if they had been consulted when it was written. They said, "No I'm not sure about that one." We checked people's care plans and found that they did not detail that people or their family member's had been involved in their production. There was no evidence that people's views had been sought, or that meetings had taken place to discuss their needs.

We spoke with the provider about this. They told us that they agreed that care plans did not show people's involvement and had started taking action to resolve this. As part of the introduction of a senior carer role, senior staff would be allocated a number of people's care plans to go through with them and ensure that the person and their relatives were involved. We saw that this process had started in some care plans; however these were not yet complete.

There was information about the service and the care that people could expect. Staff members explained that when people moved in, they were given a guide which included useful information about the service, as well as external organisations which people may need to know about, such as the Care Quality Commission. There was also information on display in communal areas of the service, such as the staff on duty, menu's and activity plans. This helped people to know how the service was running on a day-to-day basis.

People told us that they were happy with their care and felt that they were treated with kindness and compassion by members of staff. They explained that they felt relaxed and at home in the environment and that they felt they had positive relationships with members of staff. One person told us, "They're very good here, it's very homely." Another person said, "Oh yes, we're well looked after."

People's family members were also positive about the service and felt that their relatives were well cared for at the service. They told us that they could see that their family members were happy at the service and had built good relationships with members of staff. One family member said, "I have no complaints about the home, mum is very happy here." Another said, "My mum likes it here."

Staff members were positive about their roles and valued the people that they cared for. They told us that they worked hard at getting to know people and building up a strong rapport with people, as well as their family members when they came to visit. Staff told us that they were able to spend time talking with people to help them feel comfortable and relaxed, rather than just meeting their care needs. One staff member said, "It's quite laid back, you have time to sit with residents and have a laugh and a joke." Throughout our inspection we saw that staff treated people with kindness and made sure they engaged in social, friendly conversation with them, rather than just talking about their care needs.

People also felt that staff treated them with dignity and respect. They told us that staff always made sure they had what they needed and spoke to them politely, referring to them by their chosen name and respecting their preferences. They also told us that staff made sure their privacy was upheld and made sure

confidential information wasn't available to other people living at the service. Staff members told us that they felt it was important to respect people and treat them with dignity. They explained that this went beyond making sure they had privacy with tasks such as personal care, it also included how they treated the environment. One staff member said, "It's like I am in their home." They went on to explain that this meant they treated the service as somebody's home, rather than a place of work.

Throughout the inspection we saw that people were treated with respect and dignity. Staff spoke to people with patience and politeness and made sure they had understood what had been said. They were discreet when supporting people with, or reminding them about, personal care tasks and made sure that they did not discuss confidential personal information where others may be able to hear it. If people required help with personal care tasks, staff made sure their dignity was maintained throughout and that doors were shut, to afford them some privacy whilst the task was carried out.

People were also able to receive visitors at any time. People and their family members told us that they were able to come and go and that staff were always warm and welcoming towards visitors. We saw staff welcome visitors to the service and were happy to talk to them, however they also ensured they had the time and space they needed to have their visit. People could choose where they received visitors. They could speak to them in their bedroom or in communal areas of the service. There was a second lounge area which was smaller and allowed people to have a comfortable visit in privacy, if they so wished.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive person-centred care, in accordance with their own views and wishes. We spoke to staff and the provider about person-centred care plans. They told us that they had identified that care plans were not as person-centred as they could be, and planned to review all the care plans in the service to ensure they were person-centred in the future. They explained that by allocating specific files to senior staff, they felt that it would be easier for them to review these plans and keep them updated and person-centred.

We looked at care plans and found that they lacked person-centred information, which staff needed to know to enable them to deliver personalised care. Care plans gave basic information about people's care needs, however did not always demonstrate an understanding of people's needs and preferences. For example, people diet and nutrition care plans in place. These provided staff with information about specific dietary requirements, such as allergies, but did not always record the meals that people liked to eat or where they preferred to have their meals. We also saw that a review of some care plans had started. These plans were more person-centred, however were not complete and still required some work to ensure they were a true reflection of people's needs and preferences.

Staff members told us that a pre-admission assessment was completed before people moved into the service. They explained that management met with the person and their family to assess them and gather information about their needs and preferences. We looked in people's care plans and saw that pre-admission assessments had been completed to provide the service with useful information about people's specific needs and health conditions.

People told us that staff were aware of their individual wishes, and make sure that they were respected each day. One person described how staff always checked where they would like to eat their meals, and made sure they respected their answer. Throughout our inspection we saw that staff had an understanding of people's needs and wishes and worked hard to make sure they were met. For example, one staff member was able to explain to us in detail how each person liked to take their medication, so they adapted their practice to make sure that each person received it the way they wanted. When we checked the care plans we found that this information was not recorded. This meant that new or less experienced staff members may not have the knowledge to provide that individual with care the way they wanted it.

People told us that staff supported them to take part in activities when they wanted to. They explained that they did a range of different activities, both individually and as part of a group. One person told us, "I like to have my hair done by the hairdresser and get my feet done. They call them when we need them." Staff members told us that there was an activity schedule and each day there was something for them to do with people, however they remained flexible in their approach, so that people could do something different if they wanted to.

We saw that there was an activity timetable on the wall to provide people and staff with guidance regarding the activities due to take place. We saw that staff engaged with people during activities and sat with them to

go through pictures and memory boxes to help keep them stimulated. Staff also told us that they were able to go out for walks in the local area with people if they wanted to go out, and that there was a local shop nearby which some people liked to visit.

People and their family members told us that they were willing to complain if they had any problems with the way that care was provided. They told us that if they had any issues they could raise them straight away with members of staff, and that something would be done about it. None of the people we spoke with had made a formal complaint to the provider; however they had given feedback about the care that they received. One family member explained a concern that they had raised, and the response they had received from the provider. They told us, "Oh they got in touch with me and dealt with it."

Staff members told us that feedback and complaints were welcomed and encouraged, as it helped them to develop the service that they were able to deliver. We saw that the provider had a complaints policy in place and had systems in place to record formal complaints and the action they took as a result. They also told us that they planned to implement a log to record verbal complaints or feedback, so that they could ensure they had dealt with people's concerns fully.

Inadequate

Is the service well-led?

Our findings

There was a lack of effective quality assurance processes at the service. The provider had not taken steps to ensure that there were sufficient checks and audits in place to monitor the quality of care that people received, or to identify areas for improvement. We spoke to members of staff about the checks that took place at the service, however they were unsure about what checks took place and how frequently they were carried out. They were unable to tell us what audits had been completed and were not aware of action or development plans in place to help the service develop.

We checked quality assurance records and found that regularly scheduled checks had not taken place. For example, a monthly medication audit had not been completed between August 2015 and March 2016. Those that had been completed had not identified gaps in medication records and did not compare physical medication stock with records, to ensure that there were no anomalies. The systems that were in place were not completed regularly and did not ensure that the registered manager and provider had suitable assurances that medication was being given to people safely and in accordance with best practice guidance. This meant that people were at risk of not receiving their medication correctly as medication records and storage conditions were not checked regularly. Unsafe practice had not been identified and therefore steps had not been put in place to rectify this practice, meaning it may be repeated.

There were no systems in place for the regular audit of people's care plans. Staff members told us that this task had, until recently, been the responsibility of the registered manager. They explained that the introduction of the senior role at the service meant that these staff members would be involved in reviewing and updating care plans, however they were not sure how these would be checked by the registered manager or provider. One staff member said, "Well there isn't a system that I am aware of for this." We spoke with the provider about this. They told us that they had identified this as an area for development and they, in conjunction with senior staff, would be conducting regular reviews of all care plans and adapting them to make them more person-centred.

We found that the content of care plans was not checked regularly to ensure that they were accurate and up-to-date. There were discrepancies between information within people's files, which had not been identified by the service; therefore no remedial action had taken place. In addition, the lack of regular audit and managerial oversight had meant that care plans had not been modified to ensure that they were more person-centred. People's care plans had not been regularly reviewed or updated. There was a risk that people may receive incorrect or inappropriate care, treatment and support. Care plans may not reflect specific conditions or changes to people's care needs, therefore staff did not have up-to-date guidance regarding people's care. Systems were not sufficient or effective enough to identify where this was the case.

Accidents and incidents had not been routinely analysed to identify trends and patterns which may affect specific individuals. Staff members told us that they ensured incidents were reported and handed their reports to the registered manager. They were not aware of any action that was taken as a result of these reports being completed, or how the forms were used to develop the service.

We saw that incident reports had not been reviewed by the registered manager, therefore there had been no analyse of the cause of the incident, or the actions taken by staff as a result. This meant that accidents or incidents may occur again in the future as there had not been any organisational learning. We did see that the provider had carried out an analysis of falls within the service, identifying the times and locations within the home where falls were most likely. This information had been displayed within the service; however no action had been taken as a result of this analysis. For example, it was noted that there was an increased risk of falls during the staff afternoon handover. The provider was unable to tell us about any changes they had made as a result of this; therefore the risk to people had not changed. The provider had failed to review incidents and accidents and learn lessons to improve people's future care. This meant that trends and patterns for different types of incident were not identified, therefore proactive action had not been taken to prevent a repeat of similar incidents occurring again.

The provider told us that they carried out a monthly health and safety audit of the service. This identified areas of the service which required maintenance or attention and they used it to plan actions which were required. We saw that the provider had carried out a regular health and safety audit of the service, which included checking fixtures and fittings and that actions had been implemented; however found that the audit had failed to identify some areas of disrepair within the service. This meant that this check was not always carried out effectively to ensure that the environment was safe and secure, therefore people could be at risk of harm from areas of the service which were not fit-for-purpose.

Staff records were not always kept up-to-date. Staff training and supervision had not been carried out or recorded on a regular basis and the information available was not up-to-date. There were no checks or audits of staff files, therefore the provider was not aware that staff had not received regular supervision, or that the training matrix had not been updated with the most recently completed training. This meant that the provider was unable to demonstrate that staff members had up-to-date skills and knowledge to perform their roles and were not able to assess where development was needed in this area and make appropriate plans.

The lack of effective systems of audits and checks carried out by the service and provider meant that people's care was not reviewed and analysed on a regular basis. This meant that areas for improvement or problems were not identified. Risks were not identified and managed and care plans were not person-centred or specific to people's needs, however the provider had failed to identify this, and therefore had not taken necessary action to drive improvement.

The provider had failed to implement sufficient systems to monitor the safety and quality of the care that people received, as well as the environment. This meant that people were exposed to risks of potential harm as well as the risk that they would receive care or treatment that was not in accordance with their current needs. The lack of quality assurance systems meant that the provider and registered manager were not aware of the risks that were posed to people, visitors and staff, or of areas of care delivery which were in need of improvement.

There were not sufficient systems or processes in place to assess, monitor or improve the quality and safety of the services provided. The provider had not evaluated and improved their practice as a result of quality assurance processes. This was a breach of Regulation 17 (1) (2)(a)(b)(c)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of clear and effective management at the service. People and members of staff were aware of who the registered manager was, however told us that they were often absent from the service. One person told us, "I haven't seen her for a bit." We spoke to the provider about the registered manager. They

told us that the registered manager was currently working their notice period, as they had resigned from the position. They also told us that they were in the process of recruiting a new manager, who would register with the Care Quality Commission (CQC), once they were in post. They told us that they had shortlisted for the role and the potential candidates had experience of managing services; therefore they were aware of their regulatory obligations. This included submitting notifications to the CQC of certain incidents, such as safeguarding concerns or incidents that stopped the service from being delivered.

Members of staff told us that the provider was supportive and helped them to manage people's care. They told us that they provider had spoken to staff about how they could improve the service and had identified areas of concern, such as the lack of quality assurance. They told us that the provider had introduced a new senior carer role. This would allow tasks such as care plan management and review to be carried out by seniors, which would ensure that they were up-to-date and more person-centred. The provider was confident that with the implementation of this role, the service would start to make the necessary improvements.

There was a positive and open atmosphere at the service. People were happy with the care they received and the staff that provided it. Staff members told us that they had worked hard to create a homely and positive environment for people to live in and call 'home'. One staff member told us, "I love my job, I love coming in and helping people and spending time with them." We saw that staff were motivated to make a difference in people's lives and provide them with the best care that they could. Throughout our inspection staff, and the provider, were happy to talk to us about what was going well at the service and areas that needed to be improved.

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 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 11 HSCA RA Regulations 2014 Need for consent The service had failed to ensure that they had sought people's consent when writing their care plans. Where people lacked mental capacity to agree to their care, they had not carried out suitable assessments of their capacity, in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been assessed regularly or robustly. Sufficient steps and control measures were not in place to mitigate risks and reduce the likelihood of people suffering harm. In addition, he service did not have sufficient systems and processes in place for the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse or improper treatment as systems and processes were not established and operated effectively. Incidents of potential abuse were not identified by the service, therefore were not reported to appropriate external bodies.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Members of staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were not sufficient systems or processes in place to assess, monitor or improve the quality and safety of the services provided. The provider had not evaluated and improved their practice as a result of quality assurance processes.

The enforcement action we took:

NoD