Aquarius Lodge

Aquarius Lodge

Inspection report

20 Approach Road
Cliftonville
Margate
Kent
CT9 2AN

Tel: 01843292323

Date of inspection visit:
26 April 2017

Date of publication:
13 June 2017

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

This was an unannounced inspection that took place on 26 April 2017.

Aquarius Lodge provides accommodation and personal care for up to 17 older people, some of whom are living with dementia. The property is a three storey detached building and bedrooms are on all three floors. There are communal lounges and a dining room. There were 13 people using the service when we visited.

In August 2016 the providers, who were previously registered as an organisation, became a partnership and the legal entity changed. The providers and the registered manager remained the same and had been in charge of the service for several years.

The service had a registered manager in post who assisted with the inspection. 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 service was not safe as the provider had failed to make sure that risks to people, staff and others had been managed to protect people from harm and ensure their safety. Risks to support people with their mobility and behaviour had been assessed but staff did not always have clear guidelines to follow to ensure the risks were managed safely.

Risks assessments to prevent people from choking did not record what staff should do if the person started to choke and may need medical assistance. People that had been assessed as at risk of falling did not always have guidance for staff in place to reduce the risks of the person falling.

Equipment to reduce the risk of people developing pressure areas had not been checked to confirm the correct settings for each person. Accidents had been recorded and logged and medical attention had been sought, however people's care had not been reviewed when their needs changed to reduce the risk of accidents happening again.

People were living in premises that had not been well maintained. Although some areas of the environment had been improved, such as a new wet room, new flooring in some bedrooms, and redecoration, there were still areas where risks had not been identified and managed.

Infection control audits had not identified the risks of infection and there was an unpleasant odour in some parts of the service. The floor of the laundry room had broken tiles and the fire door was not safe as it would not be effective in a fire. Although checks on the fire system had been made on a regular basis the fault on the laundry fire door had not been detected or recorded.

People could not access the garden without staff as this was not safe. The grass was over grown, with washing lines across the garden, which would pose a risk to their safety. Equipment was not stored safely. There was old equipment and other items, such as old curtain rails/blinds and Christmas decorations stored in the lounge on the ground floor, which led to the garden. There was an old hoist by the entrance to the garden, with wheelchairs and walking frames at the side. There were no risk assessments in place to manage these risks and ensure people were protected from harm.

The bath in the ground floor bathroom had split panelling and there was a ceiling light fitting in need of repair with exposed wires. The bathroom on the first floor had tiles. The windows were in need of repair with flaking paint and open woodwork. The registered manager told us that the windows in the lounge and one other were being replaced the next day but there were still others that were in need of repair or replacing. There were no plans or timescales for this work to be carried out.

The call bell system was not working in in all of the bedrooms, and there were areas on the ground floor which required re-decoration.

The maintenance person worked 20 hour per week and was decorating the hallway at the time of the inspection. There was no detailed maintenance plan in place with timescales as to when the outstanding work would be completed.

Cleaning materials were not stored safely so people, who may be confused, could access them. Archived files were kept in a cupboard in unlocked filing cabinets which were not being stored securely.

The towels that the provider had made available for people to use were old, threadbare, coming apart at the edges, faded and worn. Some of the bedding was not suitable as the single sheets did not fit over the mattresses and were just laid on the top. Duvet covers looked worn and faded. The registered manager told us that the provider had purchased some new flannels but there was no new bedding or new towels.

There were not always enough staff to meet people's needs, especially at weekends, when there was no cook on duty and care staff were then responsible for cooking the meals. New staff had not been recruited safely as not all references were in place to confirm new staff were of good character and were suitable to work and support people.

Staff were receiving regular supervision but had not completed an appraisal to discuss their development, and review their performance over the previous year. We have made a recommendation to ensure that all staff receives an appraisal.

Staff were receiving training however their competencies were not being checked to ensure they understood and applied the training in line with good practice. The registered manager had not received formal supervision from the provider, or an appraisal to identify their training and development to continuously develop their skills and competencies.

People's mental capacity had been assessed; however, when complex decisions had been made by others, there was a lack of clarity to confirm that these decisions had been made in people's best interests. We have made a recommendation about involving people in decisions about their care.

People and relatives told us that staff monitored their health and they received the support they needed. However, when people attended outpatient clinics the outcome of the visits was not always recorded to update staff if the person's needs had changed. People's medicines were not always given to people safely.

There was no guidance for 'as and when' required medicines, such as pain relief.

People's privacy and dignity was not always respected as staff just walked in to their bedroom without knocking before entering.

Some parts of the care plans were personalised whilst others lacked detail about people's preferences, and what they could do for themselves to remain as independent as possible. Further information was required to ensure that staff had detailed guidance about people living with diabetes and catheter care.

The activities co-ordinator worked three mornings a week which resulted in limited time for people to be supported to follow their interests and take part in social activities of their choice. We have made a recommendation about involving people in decisions about their care.

Checks completed on the quality of the service were not effective. The shortfalls found at this inspection had not been identified. The provider had not forged links with the local community to involve the service in local events.

People and staff had completed a quality assurance survey; however action had not been taken to regularly obtain the views of relatives and health care professionals.

Staff recognised different types of abuse and knew who to report any concerns to. Staff were aware of the whistle blowing policy and the ability to take concerns to agencies outside of the service if they felt they were not being dealt with properly.

The provider had an emergency plan in place to reduce the risk to people in the event of a major incident. Each person had a personal emergency evacuation plan in place. Checks on equipment, such as the regular servicing of hoists, and the servicing of boilers and equipment were in place.

People told us they enjoyed the food. Care plans contained information and assessments about how to support people with their nutritional, skin care and continence needs. People had been assessed before coming to live at the service.

Complaints were responded to appropriately. Additional signage around the building had been added as advocated by dementia care good practice guidelines

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered provider had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines

No rating of the service was on display as this was the first inspection under the new partnership registered in August 2016.

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

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to support people with their mobility and behaviour had been assessed but staff did not always have clear guidelines to follow to ensure the risks were managed safely.

Although some areas of the environment had been improved there were still areas where risks had not been identified and managed. Parts of the service were not clean and not well maintained.

People's medicine was not being managed safely.

There was not always enough staff on duty to meet people's needs. New staff had not been recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received regular supervision but had not received an annual appraisal to discuss their training and development needs.

Staff supported people to make decisions but lacked a full understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People were supported to see health care professionals when they needed to have health checks and to attend healthcare appointments.

People told us the food was good. People's nutritional needs were assessed and they received a suitable range of food and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always respected as staff

just walked in to their bedroom without knocking before entering.

People were not always being treated with respect as the provider had not ensured they had suitable towels and bedding.

People's records were not always stored securely to protect their confidentiality.

People and relatives told us the staff were kind and caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not have written information about everyone's needs. Care plans lacked detail about people's preferences and health needs. .

Activities were limited which did not give people the opportunity to take part in activities of their choice.

People had their needs assessed before they moved into the service.

There were systems in place to ensure any concerns or complaints were responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

There were no plans in place for the continuous development of the registered manager.

Checks completed on the quality of the service were not effective. The shortfalls found at this inspection had not been identified.

The provider had not acted in a timely way to ensure that people lived in a comfortable, clean and well maintained home.

The provider had not forged links with the local community to involve people in local events.

People and staff had completed a quality assurance survey; however action had not been taken to regularly obtain the views of relatives and health care professionals.

Aquarius Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, 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 26 April 2017 and was unannounced. The inspection was carried out by two inspectors. This was the first inspection since the organisation became a partnership.

On this occasion the provider had not received a Provider Information Return (PIR) to complete. 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. Before the visit we looked at notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We looked at information received from social care professionals.

During our inspection we spoke with five members of staff and the registered manager. We spoke with eight people using the service and two relatives.

We observed the lunchtime meal and also observed how people were supported throughout the day with their daily routines and activities. We looked at how staff spoke with people and observed staff carrying out their duties. We looked around the communal areas, some people's rooms with their permission and facilities such as the kitchen and laundry.

We looked at a range of records including care plans, for five people, and medicine administration records. We also looked at four staff records and records for monitoring the quality of the service provided, including audits, complaints records and meeting minutes.

This is the first inspection of the service since registration on 17 August 2016.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "Yes I do feel safe when staff support me to move with the hoist".

A relative said, "I am happy that my relative is here, they are safe. They always keep an eye on them. I am definitely confident the staff know what they are doing".

Although some people told us they felt safe there were areas of the service which were not safe. The provider had failed to make sure that risks to people, staff and others had been managed to protect people from harm and ensure their safety. They had failed to make sure that care and treatment was provided in a safe way.

Risks to people had not been consistently assessed and guidance to reduce risks was not detailed or clear. Risk assessments to support people with their behaviour lacked detail to ensure that staff had the guidance to positively support them. One person's care plan stated, 'can become confused and agitated when waiting for health care professionals' and 'can be verbally aggressive towards others'. There were no guidelines in place for staff to follow to support this person or how to reassure them if they became agitated. Whilst the plan explained the reasons why this happened there were no strategies in place to reduce this behaviour happening or re-occurring.

Another plan stated, 'I have no behaviour issues but I can get distressed and I may shout or swear but I have never been physically abusive'. ' When I am appearing agitated I prefer carers to allow me to sit somewhere quiet, I will then calm down in my own time and in my own space'. There was no information about why the person may become distressed or how staff could support them to move to a quiet area. Staff were able to tell us about this person's behaviour, how they patted their knees when they became agitated but this was not recorded in the care plan.

Some people needed support to move safely. The moving and handling risk assessments lacked the details to ensure that staff had guidance about how to move people safely. One plan stated 'I require two trained carers to put the appropriate straps on me and carry out hoisting following all training and health and safety procedures'. There was no step by step guidance for staff to move this person safely, there was no information about what hoist to use or the size of the straps, and where to place them. No information was recorded about how this person's medical condition affected their ability to move and what, if anything, they could do for themselves. Another plan also lacked detail to make sure the person was being supported safely to walk. It noted, 'I can walk independently with a walking aid and would like the member of staff to supervise me when I am walking.' This person had a history of falls. There was no indication what 'supervise' meant to this person or what staff needed to do to support this person and reduce the risk of falls.

Staff told us they moved people safely and people told us they felt safe whilst being moved, however, when a person fell during the inspector overheard one member of staff telling the person to 'stay on the floor' and

another staff member 'if they could sit up on his own, we could move them". Staff were not sure which was the best way to move the person safely.

Some people were at risk of developing pressure areas and had special mattresses and cushions to sit on. Each mattress should be set to the correct level for each person to ensure it has maximum effect. We noted that the level on one mattress was far too high, we spoke to the registered manager who immediately adjusted the level; however we could not be sure this was the correct setting as there was no information to confirm what the right level for each person should be. There was therefore a risk that people could develop pressure areas if the equipment was not checked, set to the right level for each person, monitored and working effectively.

People who had difficulty swallowing were seen by the speech and language therapists to make sure they were given the correct type of food to reduce the risk of choking. Risk assessments were in place for staff to follow to make sure the right foods and thickened drinks were given. One person who was at risk of choking had an assessment in their care plan stating that staff cut up the person's food, stayed and supervised them when they were eating their meal. However, there were no other details in their risk assessments to show staff what action they should take if the person started choking and when to seek medical advice. We observed that when this person had their meal staff were attentive and stayed with them to ensure they ate their food safely.

Staff assessed and completed a falls assessment for each person. The forms in the care plans indicated what level of risk people had of falling. Some assessments had a score of a high risk but there was no further risk assessment in place to guide staff what measures needed reduce the risk of people falling.

Accidents had been recorded and logged. There were four accidents recorded since December 2016, three of these occurred on the ground floor and one in a person's bedroom. The information had not been used to show how the risks would be managed and mitigated to reduce the risk of further accidents. There was no equipment in place, for example alarmed mats, to alert staff when people went to this ground floor area. s

The provider had failed to do all that was reasonably possible to assess and mitigate risks to people's health, wellbeing and safety. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There were areas of the service which were not safe. The laundry room had broken tiles on the floor and the worktop was not sealed, so they could not be thoroughly cleaned. The fire door had been repainted but the door seal was not in place therefore it would not be effective in the event of a fire. We noted that this repair had been carried out in November 2016 and no further work had been carried out since then. Although checks on the fire system had been made on a regular basis the fault on the laundry door had not been detected or recorded. Some fire door magnetic appliances were beeping, which was an indication the batteries needed replacement and the door would not close in the event of a fire.

Staff told us that people were supported to go into the garden when they wanted to, and the paving slabs had been re-laid to ensure they were safe and a new fence had been erected. However, there were areas of the garden which had been fenced off to restrict people from the area as there were various items such as old ladders and general rubbish. By the wall of the premises in the garden there was a supermarket trolley filled with bits of wood. The cupboard under the stairs to the entrance of the premises did not have a door and had old bits of furniture and cardboard boxes stored inside. The grass needed cutting and there was a washing line across the garden and two old round washing lines. These areas would not be safe for people

to walk and there was no garden furniture for people to sit out and enjoy the fresh air.

The lounge door leading to the garden had a sign on to say it was out of use. In the lounge there were old curtain/blind racks, Christmas decorations, paint pots with a few dining room chairs and small bits of furniture. The garden entrance door lock was broken and the door had a bolt at the top so people would not be able to open this easily. Some of the decorative tiles on the wall were broken. There was an old hoist, walking frames and wheelchairs propped up against the wall. The hand rail on the steps to the garden was only on one side and painted brown, which was not distinctive for people living with dementia to recognise and use safely.

Staff told us that people did not come downstairs to this unused lounge but there had been three unwitnessed falls in the laundry room which was situated just past the lounge. People living with dementia would not necessarily understand the sign or the hazards. The lounge door was not locked so people were able to walk in the lounge which was full of items as previously mentioned, any time they wished. There were no risk assessments in place to manage these risks and ensure people were protected from harm.

The bath in the bathroom on the ground floor had split panelling which made it difficult to keep clean. There was a ceiling light fitting in need of repair with exposed wires. The light pull switch was dirty and very short and people may not be able to reach it. There was mould on the window sill. The bathroom on the first floor had tiles chipped at the side of the bath, and the bath was stained around the plug area.

The call bell system was old and the call bells were not working in two occupied rooms and one was waiting to be fixed in another room (which was not occupied at the time of the inspection). One person had a bell to call staff which was not connected to the call bell system. A staff member said, "Sometimes there is a lack of products and faulty appliances". The registered manager told us that they were trying to source new parts but the system was so old parts were not readily available. There were no plans to replace the call bell system. People said that staff did respond to their calls when they called them.

People, staff and relatives told us that there were areas of the service that needed to be repaired, and redecorated. The corridor on the ground floor, door frames and doors were in need of redecoration as the paint was flaking and coming away from the wood. There was an open cupboard where washing powder, carpet cleaner and other cleaning materials were kept. These products should be stored behind a locked door so that people were not at risk of swallowing the liquids. There were unlocked filing cabinets with archived records stored which were not secure so there was a risk that people's confidential information could be accessed by anyone. The carpet on the stairs to the first floor from the ground floor was old and warns and needed replacing and the banisters required painting.

The windows were in need of repair with flaking paint and open woodwork. The registered manager told us that the windows in the lounge and one other were being replaced the next day but there were still others that were in need of repair or replacement. There were no plans or timescales for this work to be carried out.

The towels that the provider made available for people to use were old, threadbare, coming apart at the edges, faded and worn. Some of the bedding was not suitable as the single sheets did not fit over mattresses and were just laid on the top. Duvet covers looked worn and faded. The registered told us that the provider had purchased some new flannels but no bedding or new towels.

The maintenance person worked 20 hour per week and was decorating the hallway at the time of the inspection. Progress to maintain the premises was therefore slow and there was no detailed maintenance

plan in place with timescales as to when the work would be completed,

The provider has failed to ensure that the premises were properly used, clean, suitable for the intended purpose, and maintained. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

New staff had not been recruited safely. The provider's policy stated there should be two references for each staff member. Some staff had only one written reference and the majority of references were from friends rather than from previous employers. Other checks were carried out to make sure staff were of good character and were suitable to work with people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, one member of staff had worked with people, unsupervised without the full DBS process being completed.

The provider had failed to carry out the relevant recruitment checks to ensure that staff were suitable to work at the service. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There were not always enough staff to meet people's needs. From Monday to Friday there was a cook who prepared the meals, leaving the care staff to focus on people's care needs. There were thirteen people living at the service supported by two care staff and the registered manager. There was one domestic staff and a part time maintenance person. At weekends there was no cook and no increase in the number of care staff. One member of the care staff would be responsible for preparing meals which could lead to people having to wait to have their needs met.

The registered manager told us they had been trying to recruit a weekend cook for some time, unsuccessfully, but they had not increased the number of care staff cover the cook's tasks. One relative said, "There has been a lot of staff changes in the last three months, a lot of staff have left. Quite often there has been new staff and they need to get to know the residents". The registered manager discussed this with the provider who agreed to increase the staffing levels to include another member of staff to prepare and cook the meals at the weekends.

People's medicines were not always managed safely. On the day of the inspection there were a number of medicines in a pill pot in the registered manager's desk drawer. When we asked about these we were told they had were for a person who was asleep when staff went to administer them. There was a lockable medicines cupboard close to the registered manager's desk, where the medicines should have been stored securely. As the office was not locked there was a risk that people could access the medicines and take them by mistake. While we were speaking to the registered manager, a person came in holding a pill. They told the registered manager they had found it in their pocket. The registered manager told us the person thought they had dropped one of their pills that morning. There was a risk people may not have had the medicine's they had been prescribed.

People's medicines were managed by staff who had been trained to give people their medicines as prescribed by their doctor. The registered manager carried out competency checks on staff administering medicines to make sure they were administering people's medicines safely.
Temperatures of medicine cupboards were taken daily and were within acceptable levels. Some medicines do not work properly if stored at the wrong temperature. Staff ordered medicines as needed and disposed of any unwanted medicines appropriately.

People's medicines records were completed fully, when medicines were given. However, some medication administration records (MARS) had handwritten instructions, some of these were not signed at all, and others were only signed by one member of staff. It is good practice to have two staff sign any changes to medicine records to ensure the information recorded is correct. Some people had their medicines stopped; there was no record of who had made the decision to stop the medicine and no signature of the member of staff who made the note on the MAR.

When people were prescribed medicines 'as and when' required such as pain relief. There was no guidance for staff about what the medicine was for; how the person would let them know they needed it and how many doses they could have in 24 hours in the MAR folder. The registered manager found these documents and put them in the folder during the inspection. Some people had 'as and when' required medicines prescribed to reduce anxiety or agitation. The guidance for staff was to give the person this medicine if they were 'shouting and being verbally abusive.' However, some people shouted on a regular basis, the registered manager agreed there needed to be more detail about at what point the medicines were offered for each person.

We observed staff administering medicines to people in their own rooms and in communal areas. People were smiling and seemed relaxed. Staff gave people plenty of time to take their medicines.

The provider had failed to mitigate risks in relation to proper and safe management of medicines. This was a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements to the environment had been made. There was a new wet room and parts of the premises had been redecorated. The dining room had been redecorated and the provider had purchased new furniture. Seven of the bedrooms had been redecorated and new carpets or flooring had been laid.

The provider had an emergency plan in place to reduce the risk to people in the event of a major incident. There was guidance for staff to follow in the event of an emergency, such as, a flood or a gas leak. Arrangements had been made with a local hotel should people need to be moved out in an emergency. Each person had a personal emergency evacuation plan (PEEP) in place. A PEEP sets out the specific physical and communication requirements that each person had to ensure that people could be safely evacuated from the service in the event of an emergency.

There were records to show that equipment was checked regularly and servicing of the boilers, electrical system and nurse call system were carried out. The hoists, which were used to support people with their mobility, had been serviced.

Staff recognised different types of abuse and knew who to report any concerns to. The registered manager was aware of their safeguarding responsibilities. Referrals had been made to the local safeguarding authority when required and action had been taken to reduce the risks of incidents happening again. Staff were aware of the whistle blowing policy and they had the ability to take concerns to agencies outside of the service if they felt they were not being dealt with properly.

People's money was safeguarded. Systems were in place to record and account for any money spent. Receipts were kept and the balances were checked regularly. Some people chose how they spent their money. People had access to their monies when they wanted it.

Requires Improvement

Is the service effective?

Our findings

People told us that they saw their doctor when they needed to. They told us they were supported to stay as healthy as possible.

Staff told us that they felt supported by the registered manager who worked with them on a daily basis. They had regular supervision meetings with their line manager to discuss their development and any issues. However, no staff had received annual appraisals to plan their development and review their performance for the year. Appraisals would give staff an opportunity to identify any training needs or areas where they needed support. The registered manager told us that they were waiting to complete an appraisal training course and had discussed people's training needs in their one to one supervision meetings but no formal appraisals had taken place. Managers need training to ensure they are able to assess staff's performance effectively and to develop and improve care practice.

We recommend that the provider seeks the relevant advice and training for senior staff to enable them to complete appraisal for all staff.

The majority of training was completed online and staff had to pass a knowledge based test in order to complete the training and receive a certificate. Some staff had taken a number of times to pass the test. We asked the registered manager if they checked staff's knowledge following the completion of training, especially for those who may have taken longer to pass the test. They told us, "I sometimes talk to staff in supervision about what they have learned, but I do not have a system to check their knowledge and I don't focus on how many attempts they took to pass." There were no formal records to show that staff had their competences checked and were applying the training to ensure people received the care they needed. The registered manager told us that they would include these observations in the staff's supervision records.

Staff had training on basic subjects such as safeguarding, first aid and moving and handling. They had also completed additional training in subjects related to people's needs such as dementia and supporting people whose behaviour can challenge. Some staff had completed nationally recognised health and social care qualifications. New staff completed the care certificate, which is an identified set of standards that social care workers work through based on their competency. Staff had an induction which involved training, learning the systems in the service and shadowing more experienced staff. One member of staff told us how they shadowed experienced staff for three weeks to get to know everyone and the routines of the service.

Staff asked people for people's consent before supporting them with their care and support. They offered them choices of what they wanted to eat and where they wanted to be.

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). We checked whether the service was working within the principles of the MCA. At the time of the inspection some people had their liberty restricted. They had appropriate authorisations in place with the required related assessments to ensure the restrictions were lawful and the least restrictive.

Although mental capacity assessments were being carried out, some records did not show detailed information about how people made decisions about their care.

Each person had a mental capacity care plan which contained details of how their medical condition might affect their ability to make decisions. However, one care plan stated that the person could make day to day decisions but needed help to make bigger, more specific decisions. There was no indication of what these bigger decisions might be to guide staff how to support this person when needed.

Some people had made advanced decisions and had a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decision in place. They had made their decision with family, healthcare professionals and staff, however in one case the form had not been reviewed since 1/8/2014 and another one had been signed as 'discussed with senior carer' there was no indication of how this decision had been made or who the senior carer was.

One person, who was at risk of developing pressure areas, was recommended to have bed rest for two hours per day but there were no records to confirm if this happened. The registered manager did not know if the person had bed rest during the week as they told us they often refused to do this. The person was living with Parkinson's disease but there was no record to show that a mental capacity assessment had been carried out to assess if they had the capacity to make the decision about bed rest or to show how this decision had been made.

We recommend that the service seek further advice and guidance, in line with current legislation such as The Mental Capacity Act, Code of Practice with regard to recording and supporting people to make decisions in their best interests.

People and relatives told us that staff monitored their health and they received the support they needed. One relative said, "The staff keep me well informed, they have let me know if they have needed to call the GP. They have supported my relative to hospital appointments when I can't get here and let me know what the doctors said".

Records showed that doctors were called when people needed medical attention. People told us they saw their doctor if they felt unwell. However, one person had attended an eye clinic on 17/4/2017 but there was no record of the outcome of this meeting to update staff if the person's needs had changed. Updating people's records after health appointments with the outcome was an area for improvement.

People had access to the dentist, chiropodist and optician when required. When staff noticed a change in people's weight or people had problems eating and drinking they were referred to dieticians and speech and language therapists. Staff followed the guidance they were given by health professionals. People were supported by the community nurses for their medical conditions, such as diabetes or to provide health care to keep people's skin as healthy as possible.

Observations at lunchtime showed that people received the support they needed to eat their meals. Staff were attentive to one person who was at risk of choking and made sure their meal was cut into small pieces as they encouraged them to eat.

People and relatives told us that the food was good. People said, "I enjoy the food, the lunch was good". "Yes I always have enough to eat". One relative said, "My relative loves the food here, if they don't like what is on offer the staff always get them something else".

People were given time to eat their meal at their own pace. There was one member of staff who stayed in the dining room throughout the meal whilst others brought food and supported people in their rooms. The staff member helped people to eat their meals and offered them help to cut their food. Everyone was offered a choice of drinks. People chose where they wanted to sit and each person was able to eat at their own pace, within in the dining room, lounge or their bedroom.

The support people required when eating and drinking was assessed and people's likes and dislikes were recorded in their care plans. When people were not drinking or eating enough food and fluid charts were place in their rooms to ensure they had enough to eat and drink. Hot and cold drinks were given throughout the day and drinks were readily available in the lounge, dining room and in the bedrooms.

The cook spoke with each person every day to help and support them to choose what they wanted to eat. Special dietary needs were catered for and when required people had their meals pureed to reduce the risk of choking. One relative said, "The staff make sure my relative has the food pureed so that they can eat properly".

The cook was aware of people's likes and dislikes, and they explained how they boosted people's meals if they needed extra calories to gain weight and remain healthy.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that the staff were kind and caring. They said, "I like the staff, they are alright". "The staff are good to me" and "Staff are kind".

Relatives said, "The staff always treat my relative with dignity and respect" "The staff are always very nice to my relative". "The care here is fantastic, my relative has really settled in. The staff have got to know them really well. I feel very lucky my relative is here, it is a weight off my mind that they are so happy here."

Staff told us that they were 'compassionate about providing good care', and staff said there was good teamwork to make sure people got what they needed.

One relative said, "The staff have been great; they have welcomed all the family. Other member of my family came to visit just after my relative moved in and they were welcomed with open arms and tea and biscuits".

At the beginning of the inspection one person fell in the doorway of the lounge. Staff did not remain as calm as they could have. One staff member had to call for other members of staff to assist; when they came they called for the registered manager. Before the registered manager arrived the inspector had to ask the staff to get a cushion for the person's head to try to make them as comfortable as possible. When the registered manager arrived they spoke with the person and asked if they were in pain and called the paramedics.

Whist waiting for the ambulance, other people were trying to leave the lounge and the person became distressed as they wanted to get up. Eventually a member of staff went into the lounge to support the other people. The person on the floor began to get more distressed and staff were telling them over and over again that they needed to stay there until paramedics arrived. The inspector suggested to staff that they distract the person and talk about things that were important to them. Staff did this and the person calmed and was reassured. At one point there were lots of staff around the person which heighted their anxiety and compromised their privacy and dignity.

Staff did not always maintain people's privacy and dignity, by knocking on doors before entering their bedrooms. On one occasion the registered manager walked straight into a person's bedroom and did not knock or wait to be invited.

People were not always treated with respect as the provider had not ensured they had suitable towels and bedding.

People's care plans and associated risk assessments were not always stored securely in a locked place to protect confidentiality. Archived records were kept on the ground floor and the store room was open and the filing cabinets were not locked.

People's care plans contained information about people's life histories and about their preferences, likes and dislikes. One member of staff said, "It helps you to understand and bond with people". People were

offered choices such as if they wanted a bath or a shower, when they wanted to get up or where they wanted to sit and spend time.

People and their relatives had been involved in the planning of their care. One person told us how their relative supported them to make decisions and this was recorded in their care plan.

People's preferences, such as what food they liked to eat, were noted in the care plans. People were called by their preferred name and this information was available for staff to refer to in each person's care plan. People's rooms were personalised with their own possessions, they had their own things around them, which were important to them. One person commented, "Mr room is comfortable. I never have to ask for anything".

Some people preferred to remain in their rooms while others liked to be in the communal lounge or dining room. Staff respected their decisions and made sure people in their rooms were checked regularly to see if they needed assistance.

People were supported with any individual beliefs and people from the local church visited on a regular basis. One person told us that the local priest called regularly to give them Communion.

Some people had family members to support them when they needed to make complex decisions, such as coming to live at the service or to attend health care appointments. Advocacy services and independent mental capacity advocates (IMCA) were available to people if they wanted them to be involved. An advocate is someone who supports a person to make sure their views are heard and their rights upheld. They will sometimes support people to speak for themselves and sometimes speak on their behalf.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff were responsive and supported them when they needed help. One person, who stayed in their room, told us that staff checked that they were OK on a regular basis.

Care plans were person centred in some areas, for example, whether people preferred a bath or shower, and detailed what they could do for themselves when they had a wash. Step by step guides to supporting people with their personal care also included details such as 'pass me a towel', 'I can brush my teeth'. "Loves hair and nails done'. However, other care plans were not so detailed, One care plan said, 'able to wash face and hands, likes a shower, and like my carer to assist me with this' but there was no other information as to what 'assist' meant to this person. Another plan stated 'I require one person to assist me to shower and dress me'. There was no information as to what the person could do for themselves to maintain their independence.

Some people were living with diabetes and were being supported daily by the district nurse to monitor and administer their insulin. There were generic guidelines in their care plan to ensure that staff would recognise when a person may need medical attention if their blood sugar was too high or low. However, the care plans did not record what a normal range of blood sugars was for the individual person so that staff had an understanding of what would be normal for that person.

Care plans detailed how to support people with their continence and what signs and symptoms to look for to identify if people needed further medical support. There was information about when catheter bags needed to be changed and to inform the registered manager if there were any concerns, but no other information about what signs to look for if the catheter was not working properly.

Care plans were reviewed on a monthly basis and gave an overview of the support people had received and if there had been any changes in their care and health needs.

People were given information about the service during their pre-admission assessment. The assessments covered their personal care needs and reflected their previous lifestyles, background, and medical conditions. Personal information was also gathered, such as if people liked their door left open, or their curtains closed.

A dedicated activities co-ordinator worked three days a week and there were some group activities, such as quizzes and music. On the day of the inspection the activities co-ordinator supported one person going to a new club in the community. This resulted in no other activities for the other people living at the service and they watched television in the lounge for most of the day. There was a lack of activities for people on such occasions and people

People were only supported to socialise three days of the week. One person talked about how they enjoyed going out and looked forward to these occasions. Another person said how they liked meeting their friends. A member of staff commented, "I think there could be more activities for the people who live here".

The activities co-ordinator was using a 'My life story' book, designed by Dementia UK, to involve people in reviewing their past life events and to help staff understand more about the individual and their experiences. Staff told us there were plans for sensory gardens but this had not happened and the garden was not safe for people to access on their own.

We recommend that the service speaks with people about their hobbies and interests and plans are put in place to ensure they are actively supported to enjoy meaningful activities of their choice.

Some areas of the environment had yellow lines on walls to help people remember where the toilets were and the handrails were scheduled to be painted red. Coloured plastic had been placed around light switches to make them easier to see. The registered manager told us that staff wanted to make a 'memory room' and wanted to raise the funds for this to happen. Progress was slow and this had not been achieved at the time of this inspection.

Information about making a complaint was displayed on notice boards around the service. People told us they would speak with the staff if they were unhappy. Relatives said that they did not have any concerns.

Staff told us that they could tell if people were unhappy. They said those that were able, would tell them and people with less communication skills would present body language or present negative behaviour which would indicate something was wrong. There was a complaints policy in place; a copy was displayed on the notice board in the entrance hall to the service. There had been no complaints received since the registration of the service in 2016.

A relative told us, "I don't have any concerns or complaints but if I did I know I could go straight to the registered manager and they would sort things out. The registered manager told me the first day my relative moved in that they were always available and would address any worries straight away."

Inadequate

Is the service well-led?

Our findings

People knew the registered manager and told us the service was good. Relatives told us that they thought the registered manager was approachable.

Although the legal entity of the organisation had changed to a partnership in 2016, the providers remained the same as did the registered manager. Since the change to the registration there had been some progress to the repairs and maintenance of the premises, however the provider was not acting in a timely manner to make the improvements required to ensure the premises was safe. The registered manager told us that the provider had spent lots of money to improve the service in the last year but realised there was so much more to do. New flooring in bedrooms was ongoing and out of the fourteen rooms that required new flooring one had been replaced. The timescales for the rest of the flooring stated 10 months but this could not be measured as there was no original date on the action plan.

The action plan to improve the garden was dated 9 October 2016 and although new fencing had been erected, and the paving slabs were levelled there were no timescales to achieve the outstanding actions such as the slope to be fitted with anti-slip matting, planting bedding plants, cutting the grass, removing the rubbish and providing new garden furniture.

The refurbishment plan, dated September 2016, did not have timescales as to when the work would be completed and although some rooms had been redecorated there were two that required redecoration and one required a new sink.

The action plan to repair and replace the fire doors stated that work commenced in September 2016 but there were no timescales as to when this would be completed. Four doors had been ticked off as completed, and this included the laundry door which was still outstanding. The plan stated the laundry door was repaired and completed on 8 November 2016 but at the time of the inspection the door was not safe as the repair had not been completed which would result in the door not closing in the event of a fire. The registered manager was aware of this and had not taken action to make sure the premises was safe.

Relatives and people said that access to the garden could be improved and had noticed there were areas in the service which required attention. One relative said, "The place may not be the prettiest but the care is very good".

The provider visited the service regularly but had not identified the shortfalls identified at this inspection. It was clear that there were areas of the service which were still in need of repair and redecoration, and towels and sheets needed to be replaced.

The provider had not ensured that the premises were safe. Various items of furniture, old light fittings and blinds together with various pieces of equipment were just left downstairs on the ground floor in the lounge. There was a sign on the door which said 'not in use'. This lounge leads directly to the garden where the door was not very secure. Two people's bedrooms were on the ground floor and people came down to this area

via the stairs from the lounge upstairs. The sign was not effective to stop people from going into the lounge area as people living with dementia would not understand that the lounge was not in use. There were no risk assessments in place to ensure people were safe.

People had fallen in the laundry room. These falls had been unwitnessed as the people had independently walked down the stairs. The laundry room was not safe as there were trip hazards (broken tiles) on the floor and the fire door was not working properly. The provider had not put measures in place to reduce the risk to people to ensure they were protected from harm.

Accidents had been recorded and logged. There were four accidents recorded since December 2016, three of these were falls in the downstairs area and one in another person's bedroom. There was a chart showing the times of accidents and there was a list which was called an audit but there was no summary or learning from the accidents. When people had fallen in the laundry room action had been taken to address their injuries, but no further risk assessments or measures had been put in place to reduce the risk of further events. On one occasion the staff had to be alerted by another person living at the service before realising someone had gone downstairs and fallen.
The provider had not taken appropriate action to mitigate risks and keep people safe.

The provider had failed to make the garden safe for people to enjoy outside activities. One person had commented in the quality assurance survey that "I would like more access to the outside". There was no evidence that this request had been noted and the person was still unable to access the garden due to the amount of rubbish and overgrown grass.

The quality audits and checks in place were not effective. An audit on the staff files was carried out in April 2017 and did not identify the shortfalls found at this inspection, such as the lack of references for some staff from previous employers. The audit of 21 April 2017 stated that a person only had one reference instead of two and this had been chased but there was no further outcome recorded if this had been received.

The provider had failed to provide linen and towels of a good standard for people to use. One member of staff said, "We need more sheets, quilts etc., sometimes the rooms are clean, but the beds look tatty". Another staff member said, "I may recommend the home to others when home comforts improve".

The registered manager told us that they were decorating the hallway as the premises needed to be improved as poor decoration did not encourage people to come and live at the service.

People and staff had the opportunity to provide feedback about the service. Staff had been sent a survey in March 2017 and this was in the process of being summarised. Staff commented "The facilities are getting better" and "Sometimes there is a lack of products and appliances". The registered manager had not yet followed up such comments to ensure the continuous improvement of the service.

People and staff had been sent a quality assurance survey and the registered manager was waiting for the full responses before summarising the outcomes. Relatives and health care professionals had not been sent surveys to give them an opportunity to feedback their opinions about the service.

The registered manager could not find up to date residents meetings and the last meeting was over six months ago. The registered manager told us that a residents meeting was planned for that day but there was no information on the notice board to confirm this.

Records were not always completed properly or did not contain the information needed to ensure that

people were receiving the care they needed. For example, pressure relieving mattresses were not being monitored and checked to confirm they were working properly. When people visited the eye clinic or came back from hospital, records did not always show what the outcome of the visits were to ensure that staff were updated with people's current needs. Fluid charts did not have the amount of fluid people needed to drink to remain healthy, and were not totalled each day to be able to measure if they were having enough to drink. There were checks in place to ensure the temperature of the water was safe, which ranged between the accepted levels, and window restrictors were also checked, however the records had not been consistently signed to confirm the restrictors were in good working order.

The provider had failed to provide the registered manager with one to one supervision meetings or an annual appraisal. There were no plans in place for the continuous development of the registered manager. There was also a lack of opportunity for the registered manager to attend local forums or workshops to share good practice and network with other providers. The provider had not forged links with the local community to enhance people's lives and wellbeing.

Staff told us they felt supported and had attended staff meetings, The minutes of the last staff meeting were more of a list and did not show what, if any, issues had been raised and there was no further information recorded to confirm what had been discussed or any action that needed to be taken.

The provider had not made sure that the service had systems and processes that assessed and mitigated the risks to service users in relation to their health, safety and welfare and that these systems improved the quality of the service. The provider had not sought stakeholder's views to improve the service and not all records were accurate and up to date. Records were not clear or accurate. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014

Staff discussed how they cared for people with dignity and respect. They told us that they treated people as they would like to be treated themselves, respected their beliefs, and upheld their preferences and choices. Staff told us that they worked well as a team to make sure people had the care they needed. They said the registered manager was approachable and supported them to carry out their roles.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. The registered provider had not assessed the risk of detecting and controlling the spread of infection by ensuring cleanliness was maintained. The provider had failed to mitigate risks in relation to proper and safe management of medicines, the premises and the health and safety of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider has failed to ensure that the premises were secure, properly used, clean, suitable for the intended purpose, and maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to carry out the relevant recruitment checks to ensure that staff were suitable to work at the service.

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 The registered provider had not made sure that the service had systems and processes that mitigated the risks to service users in relation to their health, safety and welfare and that these systems improved the quality of the service. Records were not clear or accurate

The enforcement action we took:

Warning Notice served