Complete Professional Care Medway Ltd

Hempstead Care and Respite Centre

Inspection report

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Date of inspection visit:
26 September 2017
27 September 2017

Date of publication:
14 November 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place over two days, 26 and 27 September 2017. The first day of the inspection was unannounced. We told the provider when we were going to return for the second day of inspection.

Hempstead Care and Respite Centre is registered to provide accommodation for people who require personal care for up to seven people. There were four people living permanently at the home and one person staying for a short period of respite care at the time of the inspection. A respite service provides care for people who do not require a permanent stay in the care home. For example, when people's circumstances meant they needed to have a break from their home, or when their day to day carers required a break. People had varying needs, some people were cared for in bed and others were independently mobile with support. Some people were living with dementia.

The accommodation was spread over two floors with bedrooms on the ground floor and the first floor. A stair-lift was in place for people to access the first floor if required. Some rooms had en-suite facilities and all rooms had a washbasin. At the previous inspection, on 21 and 23 February 2017, the provider was also running a small established day centre from the back of the same premises and the two services shared facilities such as the kitchen area. The day centre was now closed so no longer operated from the premises.

At the last comprehensive inspection, the service was rated Inadequate overall and was therefore placed in to special measures.

We previously carried out an unannounced comprehensive inspection of this service on 21 and 23 February 2017 when we found three continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to; Regulation 12, adequate risk assessments were not in place to keep people who use services and others safe, accidents and incidents were not investigated appropriately and fire safety precautions were not adequate to keep people safe. The management, administration and the recording and storage of medicines were not safely maintained; Regulation 17, the provider did not have a quality monitoring process in place to ensure a safe and good quality service was being provided and Regulation 18, staff had not received adequate supervision and training. An assessment process to determine the numbers of staff required to meet the needs of people was not in place. We also found a further three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to; Regulation 9, the provider had failed to give people the opportunity to engage in meaningful activity; Regulation 11, the basic principles of the Mental Capacity Act 2005 had not been complied with; Regulation 13, a best interests process was not followed in relation to the use of restraint when people may lack capacity to make a decision and give their consent.

We asked the provider to take action to meet Regulations 9, 11 and 13. We took enforcement action against the provider and told them to meet Regulation 12 by 26 May 2017, Regulation 17 by 30 June 2017 and Regulation 18 by 26 May 2017.

The provider sent us a report of the actions they were taking to comply with Regulations 9, 11 and 13 on 15 May 2017. They told us they would be meeting Regulation 9 by 22 May 2017, Regulation 11 by 18 May 2017 and Regulation 13 by 15 May 2017.

At this inspection on 26 and 27 September 2017we found the provider had made minimal improvements to the service and standard of care. Staff were now recording their interactions with people although people were still not engaged in meaningful activity. A safer process was in place for the administration and storage of medicines, although there were still areas of concern. Staff had received one to one supervision meetings with their manager and staffing levels were adequate to meet the needs of people.

Many improvements had not been made and we found continuing breaches of regulations from the last inspection. These related to Regulation 9, 11, 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to; Regulation 15, the premises were not kept to a clean and suitable standard and Regulation 16, complaints had not been investigated and outcomes had not been recorded or informed to the complainant.

At the time of our inspection a registered manager was not employed at the service. The last registered manager had deregistered with the Care Quality Commission on 22 July 2015 and there had been no registered manager in post since then. 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.

We were told a member of staff was managing the service and was applying for registration with CQC. They were not available during the inspection as they were on annual leave. The provider's nominated individual was present throughout the inspection. A nominated individual is a person involved with the service that the provider has informed CQC is the individual they have nominated to provide information on their behalf.

Risk management was not effective. Individual risk assessments had not been undertaken to detail the guidance required to keep people safe. Individual risks were observed and risk assessments had not been undertaken to prevent harm.

Although the management of people's medicines had improved, this needed to be developed further.

The premises were not kept clean, this was evident through observations and the lack of recording in the cleaning schedules. Environmental hazards around the premises had not been identified to protect people, staff and visitors from harm. The premises were in need of refurbishment to provide the facilities people needed. Further improvements to fire safety systems and procedures were required to ensure people were protected in the event of a fire.

Staff did not have the training required to carry out their role. Many staff had not completed the mandatory training required. Some important training had not been undertaken by any staff.

People had not been supported appropriately to make decisions and choices when they may lack the capacity to do so. Gaining consent to care had not been explored and recorded in accordance with the Mental Capacity Act 2005. Restraining practice was used without the necessary consent or processes being followed.

People were not supported to maintain their well-being and avoid social isolation by being encouraged to take part in activities to suit their interests. Assessments and care plans did not provide the detail required to be assured people's needs and wishes were addressed to deliver the appropriate care and support. People and their relatives were not involved in reviewing their care.

Evidence was not provided that complaints received had been investigated and responded to as the complaints procedure stated.

The provider had not developed a monitoring system to ensure the quality and safety of the services they provided. Daily documents were not consistently recorded to evidence that necessary care was provided. The provider had asked people and some relatives to give their views, however systems were not in place to analyse the responses and act on them to drive improvement.

Food was stored in the fridges and freezers without a label to show the date the food was opened to ensure food safety standards. We have made a recommendation about this.

The provider's service user guide was unchanged from the previous inspection when we made a recommendation to review it as the information was hard to follow and there was conflicting advice. We have made a recommendation about this.

Staffing levels had improved, there were enough staff to provide the care and support people needed. Staff were now receiving one to one supervision with their line manager and most staff had the opportunity to have an annual appraisal to support their development. Regular staff meetings were now held.

The provider continued to use safe recruitment practices to make sure only suitable staff were employed to work with the people living in the service.

The provider now had a business continuity plan in place to provide guidance and information for staff in the event of emergency situations.

Staff knew people well and were able to give examples of people's likes and dislikes and the care they received. People were supported to be as independent as possible and their privacy was maintained.

People were happy with the food provided and they were given a choice of what they liked to eat. As this was a small service, menus were flexible to suit people's needs and wishes. People were supported to seek advice from health care professionals when needed to maintain their health.

Staff were complimentary about the new manager and felt they had made some improvements. Staff said they worked well as a team and supported each other.

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

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

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to

reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments continued to be ineffective in identifying potential risks so they could be minimised.

Medicines were not managed in a safe way.

The premises were neither clean nor suitable to meet people's needs.

The levels of staff were suitable to provide the care and support to meet people's needs. Robust recruitment processes were in place to ensure staff were of suitable character to work with people living in the service.

Staff had a good understanding of how to safeguard people from abuse and who to report concerns to.

Is the service effective?

Inadequate

The service was not effective.

People were not supported appropriately to ensure their basic rights were upheld within the principles of the Mental Capacity Act 2005.

Staff had not completed training essential for their roles.

People were happy with the food and their dietary requirements were catered for. Health needs were met and referrals were made to health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider's service user guide did not provide the information required by people about the service.

Staff knew people well and could support them with their preferences.

People were supported to be as independent as possible and their privacy was maintained.

Is the service responsive?

Inadequate

The service was not responsive.

People were not supported and encouraged to maintain their interests and engage in meaningful activity.

Care plans were not effective as they did not address all the areas people required care and support. People and their relatives were not involved in reviews of their care and support.

Complaints were not investigated and responded to appropriately. Complaints were not logged and monitored in order to learn from mistakes.

People and their relatives were asked their views of the service provided, however their comments were not listened to in order to make improvements.

Is the service well-led?

Inadequate

The service was not well led.

No process was in place to check the quality and safety of the service provided.

There was no clear oversight of the service provided or to ensure care was being delivered appropriately.

Robust record keeping was not consistent to ensure people received the care they needed.

Staff were complimentary about the new manager and said they were approachable.

Hempstead Care and Respite Centre

Detailed findings

Background to this inspection

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

This inspection took place on 26 and 27 September 2017 and was unannounced. The inspection was carried out by one inspector.

Before the inspection, we looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We also looked at the action plans the provider sent us following the last inspection. We looked at Fire service enforcement and advice notices that had been issued to the provider. We used this information to help us plan our inspection.

We spoke with two people who lived at the service and four relatives, to gain their views and experience of the service provided. We also spoke to the provider's nominated individual and three staff. We asked two health professionals and one local authority staff for their views of the service.

We spent time observing the care and support provided and the interaction between staff and people. We looked at four people's care files, medicine administration records, two staff recruitment records as well as six staff training records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives surveys.

We asked the provider to send information following the inspection. They did not send this in a timely manner as we had to request the information on six separate occasions and did not receive all the information we asked for.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 21 and 23 February 2017 we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to Regulation 12, Safe care and treatment and Regulation 18, Staffing. Risks had not been adequately assessed to prevent harm and medicines had not been managed effectively, nor had staffing levels been based on peoples' individually assessed needs. We took enforcement action against the provider to ensure they met Regulations 12 and 18 by 26 May 2017 so that people were cared for safely.

At this inspection we found that the provider had made improvements to staffing levels and there were enough staff on duty to care for people living in the service. Some improvements had been made to the management of people's medicines although there was still a need for further improvement to keep people safe. However, effective risk management systems were still not in place to minimise risk and prevent harm. In addition, further concerns were found around the cleanliness and upkeep of the premises.

People and their relatives told us they felt safe at the service. One person said, "Yes I think I am safe" Relatives commented, "Yes, [my relative is safe]. They look after [them] well" and "Yes, I think [my relative] is safe there, they know [their] ways". However, the evidence we found did not support this.

The provider had failed to make improvements to the risk assessment process, fire procedures and the safe management of medicines. This meant that people were not provided with safe care and treatment. Individual risk assessments were not effective as they did not identify the measures that needed to be in place to help prevent and minimise harm to people. One person's 'risk management plan' identified potential risks in the areas of medicines, mobility, food intake and using the bathroom. A general assessment to describe the risks to the person in these different situations contained limited detail and a lack of regard to the person's individual needs. The level of potential risk to the person in each situation had not been evaluated as a guide to staff to keep them safe. Another person's care plan identified six areas of risk; personal care, food and fluids, pressure sores, behavioural problems, medicines and mental health. Limited guidance was given to staff as to what the hazard was and how to minimise the risks identified. For example, when providing personal care, it had been highlighted that staff needed to wear gloves to prevent infection but potential hazards such as moving and handling had not been identified. A pressure area risk scoring tool for another person was ineffective as it was incomplete. If the tool had been completed correctly, if would have shown that the person was at high risk of developing pressure sores. Guidance to staff as to how to keep this person safe and prevent harm was missing. Therefore, assurance was not available that staff knew what actions to take to keep people safe and minimise the harm caused by identified risks to their health and safety.

Other individual risks observed during the inspection had not been fully considered as part of the risk assessment process. For example the risks of; catheter care, bed rails use, falls, choking, moving and handling or social isolation. One person had a catheter in place. A 'catheter passport' had been provided by the community nursing team. The nurse recorded they had routinely changed the catheter on 25 April 2017. The record stated the next planned catheter change was on 4 July 2017. There was no record either in the

catheter passport or in the care plan that this had taken place. This meant the person could have been at risk of infection. A system was not in place to record when this procedure had taken place or to provide guidance to alert staff what they should do if the community nurses missed their visit. One person had bed rails in place. No specific risk assessment to identify the risks posed by the presence of bed rails and to put measures in place to minimise those risks to prevent harm were in place. Another person was at risk of choking and of falls. These were areas that had been identified, however only a basic reference was made to the risks. A risk assessment stated, 'At risk of choking and falls when shaking bad so don't encourage to eat or walk at these times'. No further detail was recorded to give appropriate guidance to staff. A robust process was not in evidence to identify and minimise risks to people's health and safety and keep them safe from harm.

One person had a patient alert card alerting anyone who was in contact with the person to the fact they were taking a medicine which had potentially serious side effects. Although information regarding the risks and side effects when taking the medicine had been displayed on the person's bedroom wall, an individual risk assessment was not included in their care plan identifying control measures required to minimise the risks. We had highlighted this as a cause for concern at the last inspection, but the required action had not been taken. Evidence was not available that staff knew what actions to take to keep people safe and minimise the harm caused by potential risks to their health and safety.

Improvements had been made to the fire safety processes but they had not been sufficient to ensure people's safety in the event of a fire. Fire drills had identified a number of actions to improve the response of staff, but these had not been carried out. These included; ensuring fire marshals were clear about their roles and responsibilities, that staff understood how to follow the guidance in people's PEEP's, and training in fire evacuation and using evacuation chairs.

An evacuation chair was in place leading to an external fire escape. The evacuation chair was available to support evacuation down the external fire escape at the back of the premises. However, a similar evacuation aid was not available to aid emergency evacuation down the internal staircase leading to the front of the premises. If a fire broke out in the back of the premises blocking off the evacuation chair and the external fire escape, there would be no means to support people with mobility difficulties to escape down the internal staircase. This had not been identified as a risk and control measures put in place to minimise the risk and create a safe solution to prevent harm. Staff had not received any fire training, including training to use the evacuation aid if an emergency situation did arise. The need for training for this purpose had been identified and discussed in staff one to one supervision meetings in July 2017 and at the staff meeting on 20 July 2017. However, no training had been provided to staff. The nominated individual told us that they would not use the evacuation chair as they would not know how. Staff did not have the knowledge and training to support people to safely evacuate the premises in the event of a fire. This placed people at risk of harm.

Personal emergency evacuation plans (PEEP's) were in place to assist people to safely evacuate the premises in the event of a fire or other emergency. A PEEP sets out the specific physical, communication and equipment requirements that each person has to ensure that they could be safely evacuated from the care home in the event of a fire. The PEEP's contained general information including the premises fire evacuation procedure. However, they did not include specific detail about personal barriers to evacuating the premises. The format of the PEEPs used was intended for employees in a workplace, not for people living within a care home establishment. This meant that it was not fit for purpose. A description was attached as a separate document, detailing how to assist people to get out of bed with the full support of two staff and a hoist. However this, together with the PEEPs document, did not provide staff with the appropriate guidance in an emergency situation if a fire broke out and staff needed to act fast.

The hallway leading to the front door was cluttered. Three folded wheelchairs were stored in the hallway and a freestanding coat stand full of coats was next to the front door. This could prevent safe access to the means of escape in the event of a fire on the premises.

Environmental risks to people, staff and visitors when on the premises had not been identified. For example, risks such as slips, trips and falls, uneven surfaces, security or maintenance issues. Control measures were not in place to minimise risks to people, staff and visitors while on the premises to keep them safe.

Cleaning products were not stored securely as required by the Control of Substances Hazardous to Health regulations 2002 (COSHH). These provide a framework to help protect people in the workplace against health risks from hazardous substances. A bottle of bleach, surface cleaner spray, a bleach based spray and window cleaner were all stored in a cupboard under the kitchen sink that was not locked. This meant people and staff could be at risk of harm from products that were not stored safely to protect them from having a serious impact on their health.

People were at risk of using creams and ointments which had not been prescribed to them as they were unnamed and accessible to people. A bottle of prescribed shower emollient was in a bathroom cabinet and a bottle of prescribed cream was on the bathroom windowsill . People were at risk of using or ingesting these items when they had not been prescribed them, leaving them at potential risk of harm.

The provider had failed to meet the warning notice because they had failed to assess or mitigate risks to people's safety effectively. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People and their relatives told us they thought the premises were not kept clean enough and thought this was because the staff did not have the time. Staff were responsible for cleaning the premises as cleaning staff were not employed. Many areas within the premises were unclean and this was reflected by poor recording of cleaning schedules throughout the service. A member of staff said, "We all muck in with the cleaning. There is no real cleaning schedule, we use our initiative. We do have to chase some staff at times".

The first floor bathroom was unclean. This included the toilet, the windowsill and the bath-chair that was placed over the bath. Bed pans and urine bottles were scattered on surface areas. The cleaning schedule for the bathroom showed staff had carried out cleaning infrequently on 10 April 2017, 18 August 2017 and 22 September 2017. This meant the provider could not be assured that staff were doing any cleaning at all on most days. The carpets in the communal areas required vacuuming. In the room housing the medicines cabinet, a large stain was evident on the carpet. The stain had clearly been caused by the spillage of a substance such as liquid medicine as the floor was sticky when walking across it. We did not see any staff vacuuming the carpets or carrying out cleaning duties during the two days we were inspecting the service. The staircase and stair-lift were dusty and grubby. Only 53% of staff had received training in infection control even though they were responsible for cleaning the premises as well as caring for people's needs. This meant many of the staff did not have the necessary training to ensure the premises were kept to a standard of cleanliness to reduce the risk of infection across the service.

The premises needed updating and did not meet people's needs. One relative said, "It needs refurbishing and needs new flooring". People who had difficulty with mobilising did not have the opportunity to take a shower as the facilities were not available to support this, such as a wet room. People instead had to rely on a strip wash each day. Staff told us they thought improvements were needed to the environment. One staff member said, "Some places look great but they are not very caring".

The provider had failed to ensure the premises met the health, safety and welfare needs of people using them. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Improvements made to medicines practice were not sufficient to ensure the safe management of medicines. One person was prescribed Warfarin tablets. Warfarin is a blood thinning medicine. The dosage on prescription often changed, dependent on blood test results. Many packages of Warfarin tablets were in stock. The packages had arrived in the service at different times including some from the hospital. The numbers of tablets in each package were recorded on separate arrivals sheets. No further checking and counting were carried out so it was therefore difficult to be assured that the numbers of tablets left was correct. There appeared to be more tablets left than there should have been. This meant that the person may not have received their medicines as prescribed by their GP, which could have a significant impact on their health. Some people were prescribed 'As and when necessary' (PRN) medicines such as Paracetamol or Co-codamol for pain relief. These were stored in their original packaging and a record was made of the numbers of tablets to arrive in stock. However no further monitoring was carried out to ensure people had received the medicines as prescribed by their GP. One person had 12 Paracetamol left, but records indicated there should have been 10 remaining. This meant staff had incorrectly recorded how many medicines they had given this person. There was the potential other staff recording errors may have occurred, but there were no systems in place to check. No PRN protocols (taken as required) were in place to guide staff with safe administration by; recording the reason the PRN medicine had been prescribed; the dosage that could be administered; the safe amounts that could be taken; the maximum number in a 24 hour period and any side effects to be alert to. Medicine audits were not carried out to check that remaining stock matched the numbers given and to check for errors and gaps in administration so action could be taken swiftly and lessons learnt to prevent future occurrence. The lack of regular auditing meant that people may not receive their medicines safely and this would go unnoticed by the provider.

One person's care plan stated that they had assistance with their medicines and when they required more medicines their relative would collect the new prescription and medicines. However, this arrangement had changed and staff were now responsible for ordering new prescriptions and medicines. This important change had not been reflected in the care plan which meant there was a risk this person's medicines would not be obtained in a timely manner.

The provider had failed to ensure the safe management of medicines administration. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Staff told us there had been improvements in the management of people's medicines since the last inspection. They said they had a safer system now. Since the last inspection, one pharmacy was used to dispense people's prescribed medicines. Most medicines were now delivered to the service by the pharmacy in a Monitored Dosage System (MDS) for each person. MDS is a medication storage device designed to simplify the administration of solid oral dose medication. The MDS were pre-filled by the pharmacist, based on each person's prescription, before arriving at the service. Staff said they were happier with the new system as it was less complicated. One person was prescribed many medicines with complex administration requirements. The manager had negotiated with the pharmacist to deliver their medicines once a week rather than once a month to avoid the difficulties of storage and to minimise errors when changes were made mid-month to their prescription.

At the last inspection on 21 and 23 February 2017 the medicines cupboard was sited in a busy corridor where lots of people were walking past and there had been no working space to dispense medicines before administering. At this inspection, on 26 and 27 September 2017 the medicines storage cupboard was now

stored in a more appropriate place where staff could administer medicines safely.

The recording of accidents and incidents had improved and these were recorded in more detail. Each incident was reviewed by the manager or the nominated individual with the outcome documented and any necessary action recorded.

There were now enough staff to support people with their needs. Staffing levels changed if people with more complex needs visited for a period of respite care. Staff were more confident about the levels of staff. They told us they thought there were enough staff and if there were staff absences such as annual leave and sickness they covered this between themselves. Staff were clear about which people they were responsible for supporting as the day service had vacated the premises.

The provider continued to use safe recruitment practices and followed safe procedures in order to make sure staff were suitable to work with people living in or staying in the service for a period of respite care. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Employer references were also checked and gaps in employment explored. People were protected from the risk of receiving care from unsuitable staff.

Staff had a good understanding of their responsibilities in safeguarding the people living in the service. They could describe what signs to look out for and who to report to if they had concerns, including the organisations they could report to outside of the service if necessary.

The provider now had a business continuity plan in place that contained the information staff would need if situations out of the control of the provider happened. For example, inclement weather which meant staff may not be able to get in to the service, loss of utilities such as electricity, gas or water or epidemic infections. Staff contact details, utility and contractor details and contact details of people's next of kin were all up to date and included.

Inadequate

Is the service effective?

Our findings

At our previous inspection on 21 and 23 February 2017, we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to; Regulation 11, Need for consent; Regulation 13, Safeguarding service users from abuse and improper treatment; and Regulation 18, Staffing. People's rights had not been considered nor upheld within the principles of the Mental Capacity Act 2005 (MCA 2005). Restrictive practice had been used without considering people's best interests and without the application of the Deprivation of Liberty Safeguards. (DoLS) Sufficient support had not been provided to staff to ensure they had the knowledge and skills to suitably care for people. We also made a recommendation to the provider that they review how staff monitor and record people's food and fluid intake to maintain health and well-being. The provider was required by CQC to take action to meet Regulations 11 and 13. We took enforcement action against the provider to ensure they met Regulation 18 by 26 May 2017 so that people were cared for by skilled and knowledgeable staff.

Following the inspection the provider sent us an action plan on 15 May 2017 to show how they intended to improve the service and meet Regulation11 by 18 May 2017 and Regulation 13 by 15 May 2017. At this inspection on 26 and 27 September 2017 we found improvements to the support given to staff as they had received one to one supervision meetings with their manager. The recording and monitoring of people's food and fluid intake had also improved. However, serious shortfalls in training provided continued. The provider continued to fail to work within the principles of the MCA 2005 and DoLS to ensure people's rights were upheld and safeguarded.

The Mental Capacity Act 2005 (MCA 2005) 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.

The provider had failed to ensure appropriate systems were in place to ensure people's basic rights within the principles of the Mental Capacity Act 2015. The provider's action plan dated 15 May 2017 described the action they were taking to meet Regulation 11 to ensure people's basic rights within the principles of the MCA 2005 were met. This stated, 'Check list created giving various options, ensuring the service user is given the choice of what to do and when to do it to uphold their rights giving a greater freedom and choice for the service user'. A checklist had been introduced listing 'The choices residents can make for self'. The list of choices included; what to wear, mouth hygiene, skin care, when to eat, what to eat and activities. Staff ticked either 'yes', 'no' or 'sometimes' to each statement, indicating whether people could make that choice. Some people's checklist indicated they could make few or no choices and decisions. However, staff had made assumptions that service users lacked capacity when completing the checklist, without undertaking a mental capacity assessment to evidence this. There was no evidence that the checklist had been completed with each person and/or their relatives. Staff had completed one person's checklist by ticking that they were unable to make choices around when to eat, what to eat and activities. However, their care plan did not state that they were unable to make choices and decisions on a day to day basis. A member of staff asked

the person if they wanted to continue to watch the TV programme that was on the TV. The person said they did not. The staff member went through the list of options of programmes and the person made their choice. No evidence was provided to show that they lacked the capacity to make these decisions as recorded by staff on the checklist.

Each person had one mental capacity assessment in their care plan. The mental capacity assessments were not related to a particular decision and had been completed incorrectly. For example the section to record, 'The decision requiring assessment of mental capacity' stated '[person's name] has dementia' and another person's stated, '[person's name] does not have capacity'. No evidence was given why people were deemed to lack capacity. This evidenced a continuing lack of understanding of the basic principles of the MCA 2005, resulting in the risk that people's rights were not considered and the appropriate support therefore not provided.
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 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications had been made by the manager to the supervising authority to deprive people of their liberty. No authorisations had yet been granted by the supervising authority, they were still in progress. However, there was no process for carrying out mental capacity assessments prior to a DoLS application being made to check if it was appropriate to make the application.

Restrictive practices continued to be used without any evidence that people's consent had been sought or their mental capacity had been assessed and a best interests decision making process had been followed. One person had bed rails in place, however there was no reference to their presence throughout the care plan. No evidence was available to show that the person had given consent to the use of bed rails. A mental capacity assessment in order to determine if the person had the capacity to consent to the use of bed rails had not been undertaken and a best interest's process was not documented. This was raised as a matter of concern at the last inspection and no change or improvement had been made. Training for staff in the MCA 2005 had not included DoLS training. This meant that staff may not fully understand what constituted a deprivation of liberty within the MCA 2005 and therefore not have the skills necessary to ensure people's rights were upheld.

The provider failed to ensure appropriate systems were in place to ensure people's basic rights within the principles of the Mental Capacity Act 20015 were upheld. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Staff could describe how on a day to day basis they gave people choices and how they promoted their rights to do this. They gave examples of how they did this with each person, evidencing how they knew people well, despite the conflicting documentation. One staff member said, "We always promote choice as this is how people keep some control"

The provider had failed to ensure staff had received the necessary training to be able to carry out their role. Many staff had not completed the basic mandatory training to make sure their knowledge was up to date. Some crucial training courses had not been undertaken by any staff. No staff had received fire safety training so staff would not have the necessary knowledge to support people to safely evacuate the building in the event of a fire. No staff had undertaken DoLS training which meant that staff may have limited or no understanding of what may constitute a deprivation of liberty when they were caring for people. Only four out of 15 staff had completed basic first aid training; seven out of 15 staff had completed moving and handling training; eight out of 15 staff had completed infection control training; nine out 15 staff had

completed safeguarding vulnerable adults training; nine out of fifteen staff had completed MCA 2005 training and 10 out of 15 staff had completed food safety training, although staff were responsible for cooking the meals when they were on duty. One person was prescribed daily injections. Staff told us community nurses used to visit the service more than once a day to administer the injections. They said that now most of the staff team had been trained by the community nurses to administer the injections, so staff now undertook this health related task. However, there was no evidence of this training being provided. We asked the nominated individual to provide evidence of this by email. We followed this up on 3 October 2017 and again on 6 October 2017 as the information requested was not received. A further follow up by telephone on 11 October 2017 resulted in a response by email to confirm the training, 'was not certificated or documented so have arranged to be done by [health professionals training] on Friday (20 October 2017)'. The provider could not be assured that staff had the skills necessary to support people in a safe way when the evidence was not available to show they had received suitable training necessary to carry out their role.

Staff said they were unsure whether the mandatory training on offer was effective. They said knowledge gained from the training was not reliably tested. Staff told us the training method used included staff reading prepared material about the subject, followed by a test paper. However, staff were still in possession of their training material sheets while completing the test paper so could refer to these to answer the questions. This meant that staff may not have acquired the knowledge necessary to ensure their competence to provide care and support as their learning had not been robustly tested.

The provider failed to ensure staff had received the necessary training to be able to carry out the role they had been employed for. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People and relatives told us they were happy with the food provided. One person said, "The food is usually good". A relative said, [My relative] is happy with the food, they feed [them] well. They have [special dietary needs] and staff are aware of this". Staff recorded the meals people had each day in a notebook, including the amounts eaten. This meant that staff could check that people were receiving enough nutrition. They could also remind people what they had eaten recently and the meals they had either enjoyed or not. One person needed a lot of encouragement to eat nutritious meals. Staff knew how to encourage healthier eating and what was the best way to approach the subject, encouraging the person to take more nutritious food. Staff told us they knew what foods the person was more likely to eat and would often leave this on the table next to them for a period of time. Sometimes they would then eat the meal and sometimes they would not. Staff would therefore try again later. Staff told us, as it was a small service they did not have a menu to stick to, instead they asked people what they wanted to eat and based meals around what they knew people liked. A staff member said, "There is always plenty food and it is good quality". Another member of staff told us, "I have cooked four separate meals before as they each wanted something different".

Food stored in the fridge that had been opened had not been labelled and dated to show when the food had been opened. This meant there was no way of knowing how long the food should be kept for to indicate it was fresh and safe to consume. For example, there was cheese, mayonnaise, jam, butter and soya milk all opened with no reference to when they had been opened. An uncovered bowl of soup with no label was also stored in the fridge. A notice was stuck to the fridge door stating food must be covered and dated. Food items in a freezer were packaged in plastic freezer bags without labels detailing what the item was and the date it was frozen. One third of staff had not undertaken food hygiene training to equip them with the knowledge needed to understand the importance of such practices. No checks or monitoring had been undertaken to enforce food safety standards.

Some areas of the kitchen were cluttered. For example a box full of disposable cups and lids was standing in

the corner with dust suggesting it had been there some time. Plastic bags and a collection of food trays and lap trays which were stained and unclean were stacked on the floor in a corner. This could pose a risk of infection.

We recommend the provider seeks advice and guidance from a reputable source to create a system of ensuring safe standards of food hygiene are enforced and monitored.

People were supported to seek professional advice to maintain their health and well-being. District nurses, speech and language therapists and Parkinson's disease specialist nurses had visited people when needed, offering advice and treatment as necessary. A relative said, "Staff seem to know what they are doing. They have called an ambulance when concerned and called us to let us know".

Since the last inspection on 21 and 23 February 2017 staff had received one to one supervision meetings with their manager. This provided opportunities for staff to discuss their performance, development and training needs. Supervision is a process, usually a meeting or an observational assessment, where guidance and support is given to staff. All staff had a supervision meeting in July 2017 and those who were in post had an annual appraisal in March 2017. All staff had also had at least one observational assessment since the last inspection. This was in line with the provider's policy that stated staff could expect to have at least one supervision meeting every three months.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us the staff were caring and knew them well. One person said, "They [staff] are very busy, but they are all very nice". Comments from relatives included; "I think the staff themselves are good, and caring. They know what [my relative] likes and doesn't like"; "I'm impressed, they look after [my relative] well. It's a small place so suits [my relative] well"; "Most of the care workers are caring".

At the last inspection on 21 and 23 February 2017 we made a recommendation to the provider to improve the service user guide which was confusing and misleading. The service user guide was intended to give people the information they required about the service provided when they first arrived or when they were considering a period of respite care. At this inspection we found the service user guide was unchanged and no improvements had been made. The guide was long and not easy to read. Two sections gave differing information about complaints which could cause confusion.

We recommend the provider gains advice and guidance from a respected source in order to review the service user guide to provide easy to read guidance and information.

People's care plans recorded how much they could do for themselves. People were encouraged and supported to be as independent as possible. One person preferred to make their own bed in the morning and they were encouraged to do so, but staff would discreetly check and change the sheets regularly. One relative told us, "I like that they support [my relative] to be independent". Staff told us how they encouraged people to remain as independent as possible. They described how each person liked to do certain things for themselves. One staff member said, "We do promote independence, it keeps people positive. It would be quicker to do things for people but spending ten minutes more is worth it" and "Even when we are busy, we still find time for this, it builds and keeps trust".

Staff clearly knew people well and could describe each person's preferences and what was important to them. Such as, one person loved choosing their clothes in the morning and it was really important to them that they looked good. Or what time people liked to get up in the morning and go to bed at night. Staff knew people's relatives, who was important to them and what days different relatives would visit. One relative said, "I didn't used to be informed, but that's better now". Another told us, "They always keep me informed. They always keep in touch".

Staff promoted people's privacy and respect. Staff spoke to people in a respectful manner. They described how they made sure privacy was maintained when providing care and support. For example, making sure bedroom doors were closed and taking people to their bedroom or bathroom when personal care tasks were undertaken with people. However, the lack of cleanliness and general upkeep of the premises meant that people's dignity was not always respected.

Inadequate

Is the service responsive?

Our findings

At our previous inspection on 21 and 23 February 2017, we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not given the opportunity to take part in meaningful activities to protect their well-being and prevent social isolation. We found limited improvement in this. We also made a recommendation to include people and appropriate others in care plan reviews to ensure care plans reflected what people wanted and needed. There was no evidence that people and relatives had been involved in their care plans or reviews. Relatives told us they had not been invited to attend reviews.

Relatives told us there was little social stimulation. One relative said, "They don't do activities. They do look after [my relative] but they don't occupy [them]. There is no stimulation".

There continued to be a lack of activities on offer to keep people active and avoid social isolation. Most people were either cared for in bed or chose to stay in their rooms. One person who sat in the lounge watched television most of the time. This was recorded in their care plan as their favourite pastime. Other activities they may enjoy were listed, for example; going out to the local shops, card games, dominoes or going out into the garden. Staff had recorded how they chatted with the person each day and on one occasion had asked the person if they wished to go out into the garden and they declined. Staff had not encouraged the person to take part in any of the other activities listed as the person's other interests. Another person's preferences for engaging in activities were documented as reading, board games and playing cards. Their activity record had not always been completed and the records that had been kept made no reference to staff having offered any of these activities to undertake and enjoy together. Records were made of staff reading to another person at times as they were known to enjoy this. We saw one member of staff doing a jigsaw puzzle for a short period of time with one person, but otherwise did not see any attempt to engage people in interests or activities, or suggest going out to the shops or for a walk. A member of staff told us, "We don't have a lot of time to do activities as we are busy all the time".

The manager met with people once a week to ask for their view in relation to four areas; caring, safety, nourishment and activities. People scored four or five out of five for all areas except activities most weeks. Every person scored zero, one or two for activities. There was no record of what action had been taken as a result of the weekly satisfaction survey to improve activities.

The provider had failed to ensure that staff provided activities to stimulate people and encourage their personal interests. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

There was no record that an individual assessment had taken place before people moved into the service permanently or for a period of respite. This meant that the provider could not be assured that the staff had the skills and experience necessary or that the premises were suitable to meet the needs of people before they moved into the service. An assessment was required to enable staff to develop an individual care plan, providing specific guidance to ensure each assessed need was met in the way the person required and

wanted.

Each person had a care plan which described their daily routine and what they liked and disliked. For example, one person liked to have lots of cups of tea through the day with sugar and evaporated milk. Although the care plans described people's routine well, they did not address each individual need and how to ensure they received the care and support they required from staff. One person had a catheter in place and it was recorded they emptied the catheter bag themselves. A care plan to record the support required to promote and ensure good catheter care was not in place. One person was cared for in bed and although their daily routine was described, specific care plans were not in place to detail the individual elements of their needs. For example, the precise care required to prevent pressure sores or to maintain health and well-being. One person who had bed rails in place had no care plan to ensure their safe and consistent use was described and monitored. The only reference in the care plan to bed rails stated, 'If compliant, will hold on to bed rails and personal care can be done by one carer'.

Care plans had been updated in April 2017 and reviewed three monthly by a senior care worker. Changes in people's circumstances were not always taken into account when the care plan was reviewed. A health care professional had reviewed the care of one person, who had a health condition that fluctuated, on 21 June 2017. They had advised that the person 'should be assisted with eating if too shaky'. However, the care plan continued to state, 'If too shaky, keep food warm and try again later when calm'. The care plan had been reviewed on 19 April 2017 and again on 10 July 2017 when no changes had been made, despite the advice of the health care professional. We asked the person if they received support with eating when they were very shaky and they said no, staff kept their food until their shaking had calmed down.

People and their relatives were not involved in developing their care plan or in reviewing the care plan to agree any changes. Relatives told us; "No, we are not asked to do anything like that. I know there is a care plan but we have not been involved with it"; "No, we have not been involved with a care plan or reviews"; "No we have not been involved in reviews, but they do know [my relative] little ways".

The provider failed to ensure assessments and care plans provided the information necessary to ensure people's care needs were met and their well-being was maintained. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.
Complaints had not been responded to appropriately and in line with the provider's complaints procedure. A complaints file was kept in the office, however, there were no records in the file. There was one letter of complaint dated 16 March 2017, loose amongst a pile of paperwork in a filing cabinet. No response to the complainant was attached or any evidence of an investigation having taken place. The nominated individual was not sure if a response had been made to the complainant but said it may have been dealt with verbally. The nominated individual said another complaint had been received more recently. However they could not find this and did not know if any investigation had been carried out or a response made. In the resident's satisfaction survey, which included people who visited for respite care, four out of eight people had said they had no knowledge of the complaints procedure or how to make a complaint. Verbal complaints had not been logged and relatives told us they had made complaints verbally but no evidence was found of these or that improvements had been made or lessons learnt.

The provider had failed to ensure that records had been kept of complaints made and appropriate investigation, outcome and response had been undertaken. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Satisfaction surveys had been sent to people in April/ May 2017. Eight people responded, some of whom had support from a relative to complete. Most responses were positive and people gave good and very good

ratings. Two people who had stayed for a period of respite care had said they were disappointed that services they had expected to have access to had not been organised. An email exchange between the provider and the management team was recorded as having taken place in response to this comment and the provider had made a suggestion to improve communication in this regard, but there was no evidence that this improvement had been made. No further similar records were seen to address other areas that had been raised, such as ensuring people were made aware of how to raise a complaint.

The nominated individual told us they had sent survey questionnaires to relatives after the last inspection in February 2017. However, there was no record they had been sent and they could not be found. We asked the nominated individual to send the results of these surveys to us by email. We did not receive this information despite sending follow up emails on 3 October 2017, 6 October 2017 and 12 October 2017 to request again. Relatives told us they had not received survey questionnaires. One relative said, "No I have not received a questionnaire, not that I know of". Another relative told us, "We did receive a questionnaire a while ago, over six months ago I think but it was not relevant for families to fill in so we couldn't say much". This referred to a questionnaire we saw at the last inspection when we raised the unsuitability of the form.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 21 and 23 February 2017, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to have systems in place to audit and monitor the quality and safety of the service provided and to have suitable and robust recording systems. We took enforcement action against the provider and required them to meet Regulation 17 by 30 June 2017.

At this inspection, on 26 and 27 September 2017, we found no improvements. The provider continued to have no auditing and monitoring systems in place to ensure the quality and safety of the service provided.

The provider had not introduced any auditing systems to monitor the quality and safety of the service provided, despite having been served a warning notice to ensure they met Regulation 17 by 30 June 2017. We found a number of concerns during our inspection as described within this report; risks were not identified and guidance was not provided to minimise harm; medicines were not managed effectively; fire safety processes were not robust; the premises were unclean; suitable staff training was not provided or monitored; people's rights were not upheld within the principles of the MCA 2005; suitable meaningful activity was not provided and care plans were not effective; complaints were not recorded and dealt with appropriately. We found that the majority of areas of concern found at our last inspection continued. We also identified further areas that breached the regulations, which meant quality and safety had deteriorated further. None of these areas of concern had been identified by the manager or the provider as effective systems were not in place. This meant that the provider was not keeping people safe or making sure they were providing a good quality service to people as they did not have systems in place to alert them to shortfalls in care and safety.

The provider gave assurances there was a manager in post who was going through the application process to register with CQC, but there was no evidence to support this. A relative said, "It is not managed well really as the time is not given to it". A member of staff told us, "I feel [the new manager's] hands are tied. They can't always do what they would like to do". At the last inspection, on 21 and 23 February 2017, we were told the manager was 'acting manager' in the absence of the previous manager although we found that their job description had not changed and they also continued to be on the same pay grade as the rest of the staff team. At this inspection, on 26 and 27 September 2017, we found no evidence of a new employment contract or a new job description. We checked with the provider's nominated individual if there were further employment details kept elsewhere and they told us all staff details such as contracts and job descriptions were kept in their staff file. They said they were unaware of the employment arrangements with the manager. This meant a formal arrangement was not in place to ensure the appropriate management and leadership of the service was secured.

The service had been without a registered manager since 22 July 2015. Applications had been made to register the previous manager but errors were made and therefore the applications were rejected. The provider and nominated individual were not timely in their response to these issues. Following the last inspection on 21 and 23 February 2017, the nominated individual sent an email to CQC confirming, '[The

manager] has been asked to take the position of Manager for Hempstead Care & Respite Centre and [they] have accepted. We will now go ahead and begin the registration'. No registered manager application was received. On the first day of inspection, the nominated individual told us the registration application had not yet been sent to CQC, although it was completed and ready. We were told the application was submitted during the time of the inspection.

The manager did not have any management time on the staff rota, all their time in the service was when they were on shift as part of the staff team providing care and support. This meant the manager had not been given protected time to provide the management and leadership required or to develop systems and processes to ensure compliance with the regulations.

The provider had failed to ensure records of people's care had been documented accurately and consistently by staff so they could be assured people were receiving the care they required. Daily charts to record the personal care interventions by staff were not always completed and kept up to date. One person was cared for in bed and required a regular position change to prevent acquiring pressure sores. A chart was in place for staff to record each time they provided support to change the person's position in bed. The record was not completed consistently. No recording was made at all some days and other times were recorded sporadically. The dates records were made in September 2017 included 13, 15, 16, 17, 18, 22, and 25. This meant in that 13 day period no record was made for seven of those days. On the dates records had been made, times recorded were inconsistent. On 16 September 2017 the times recorded were; 15.00, 17.30, 19.30 and 21.30, on 18 September; 08.20 and 18.00 and on 25 September; 08.00, 16.35 and 20.30. This meant the person may not have been supported to change their position regularly enough to prevent bed sores. Another person had recording charts in place to document the results of urine testing. No reason was given why this was being tested and what staff were looking for or how often the urine was meant to be tested. The records showed their urine had been tested three times in February 2017 then not again until 11 June 2017. The person also had blood pressure recordings documented once on each of the dates; 22, 24, 25 and 26 September 2017. A note stuck to the front of the care plan file stated the person's blood pressure should be taken twice a day. There was nothing in the care plan to advise how often the blood pressure should be taken, which healthcare professional had advised staff to carry out the intervention and the reasons why. Another person's records showed that a healthcare professional requested on 30 August 2017 that their blood pressure be taken sitting and standing when they were mobile. A blood pressure recording chart was in place stating, '[Person's name] BP needs to be taken'. Only one record had been made of the blood pressure recording, on 28 December 2016. There was no evidence that staff had been assessed as competent to take blood pressure readings. Consistency was not maintained when completing daily recording charts to evidence that people received the support needed to maintain their health and well-being.

The provider asked people for feedback through an annual survey questionnaire. However, there was no mechanism in place to ensure the responses were analysed, listening to what people said in order to make improvements to the service provided.

The provider had failed to meet the warning notice because systems to monitor the quality and safety of the service provided had not been developed. Records were not maintained to ensure the support necessary to maintain people's health and well-being was being provided. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed on the provider's website for the location where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had not displayed

their rating on their website. We will be looking at this separately to this inspection.

Relatives told us they and their loved ones had not been given any information about the rating of the previous inspection or what the provider's plans were for improvement. Relatives did agree that some changes had been made. One relative said, "It has improved, but they are not there yet".

People did not benefit from receiving care from a staff team who felt valued and well supported. Most said they were not kept up to date with changes made or planned in the service. They said the provider had little involvement with them as a staff team. Staff were aware changes were being planned by the provider but said they were not kept informed. The comments we received from staff included, "We aren't really kept informed about changes", "We don't see much of the provider – they come in and out again and don't really talk to the staff", "There has been a big difference with [The new manager] now managing. We don't have any input with anyone else though".

Staff told us they now had regular staff meetings. One member of staff said, "It is nice to get together and make suggestions". "We do raise things at team meeting but there is not necessarily anything done". Staff meeting minutes showed discussions taking place where all staff joined in and were able to raise issues. The manager had raised areas that required improvement by staff, for example, the use of personal mobile phones while on duty and more positive team working.

Staff were complimentary about the new manager and said they felt supported by them. They said they thought the manager was trying to make changes and improvements had been made. A member of staff said, "There have been improvements [since the last inspection], daily recording and activity logs", and another told us, "I think the service is well run". Staff told us they worked well as a team and this was one of their strengths. However, we found during the inspection that only minimal improvements had been made and some areas had deteriorated.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure that records had been kept of complaints made and appropriate investigation, outcome and response had been undertaken in line with their complaints procedure.