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Derby House

Inspection report

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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

The inspection took place on 28 and 29 November 2017 and the first day was unannounced.

Derby House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home can accommodate up to seven older people who may be living with dementia. Derby House is a large detached Victorian property. Accommodation is provided over two floors and comprises of seven single en-suite bedrooms. On the first floor, there is a large open plan kitchen, dining and living room. Derby House does not have a passenger lift; residents who cannot use the stairs access the first floor by a stair lift. The care home is in a residential area of Stretford and has good access to public transport and motorway links. At the time of this inspection there were seven people living at the home.

Regarding the registration of this service, there is no condition that the provider must employ a registered manager. As such the provider managed the day to day responsibility of running of the care home and was supported by a deputy manager.

The previous inspection took place in April 2017 and was prompted in part by the notification of an incident following which a person died. This incident was subject to an investigation and as a result our inspection did not examine the circumstances of the incident but was intended to ensure the people living at the service were safe. When we completed our inspection in April 2017, we found concerns relating to medication management, consent to care, recruitment practices, staff training and governance systems. The service was rated 'Inadequate' overall and placed in 'special measures'.

At this inspection we found that insufficient improvements had been made following our previous inspection. We identified continuing breaches in the Health and Social Care Act regulations relating to recruitment, medication management, infection control and prevention, staffing training, consent to care and governance systems. We made a recommendation that the provider review best practice guidance on dementia friendly environments.

At our last inspection, we found recruitment processes did not adequately ensure suitable candidates were employed to work at the service. At this inspection we found little had changed and recruitment processes needed to be strengthened.

The provider had made some improvements in infection control and prevention practices as identified by an infection control audit. We noted not all action identified as a priority had been taken. This meant people were at risk as appropriate action to prevent the spread of infection had not been taken.

Regarding the safe administration of medicines, we identified concerns with how medication was recorded.

This was a continued breach of the regulation as people were insufficiently protected from risk of harm.

Measures to ensure people's safety such as door guards and regular fire drills were not effectively used or carried out. We noted personal emergency evacuation plans were in place and kept in an accessible location.

Staff were aware of safeguarding principles and knew what action to take should they suspect abuse was taking place. They had received relevant training in this area. This meant there were effective systems to help protect people from risk of harm.

People's liberty was restricted as the provider had not reapplied for this to be authorised under a Deprivation of Liberty Safeguards (DoLS). The provider had not ensured that staff had received relevant training to understand the requirements of the Mental Capacity Act in general, and DoLS.

The provider's induction process for new staff and mandatory training was not sufficiently robust. We identified were several gaps in training which meant staff had not completed training in key areas such as safeguarding, dementia awareness and fire training. Failure to provide relevant training and professional support meant that staff were not sufficiently supported to function effectively in their roles.

People's care and support needs were initially assessed before they were accommodated at the service. This was to ensure the service would be able to provide suitable care. Care needs were assessed holistically and covered identified support needs such as for medication, foot care and mobility. Care plans contained relevant details to help staff support people according to their individual needs.

People told us the food was of acceptable quality. This helped to maintain people's good health and wellbeing. Meals took into consideration people's preferences. The service operated a four weekly menu but these menus contained very little detail about the meals on offer.

Care records demonstrated that people living at the service had access to medical attention and healthcare professionals such as GPs and podiatrists when required. This meant that people's healthcare needs were being met in line with their individual needs.

People told us staff treated them well. We saw that there was good rapport and friendly interactions between people and staff. People got on well with the staff and staff demonstrated that they knew people well. This meant people were cared for by staff who knew their preferences and understood their support needs. However based on the lack of improvement made, we found the service had not sufficiently demonstrated the hall marks of a caring organisation.

People's dignity and privacy were treated respectfully. We saw examples of how people were encouraged to develop and maintain their independence. In so doing, the service helped to ensure people maintained a good quality of life and wellbeing.

At the last inspection in April 2017, there was insufficient meaningful activity taking place throughout the day which was suited to the people living at Derby House. At this inspection we noted some initial improvements had been made. There was no dedicated activities coordinator at the home. One of the staff had taken on added responsibility in this area. Activities included indoor games and visits from community groups. This should help the service ensure that people were engaged in suitable activity that was meaningful and stimulating.

Care plans reflected people's physical, mental, emotional and social needs and included a personal history, religious practices and communication needs. People and their relatives were involved and contributed to the care planning process.

People knew how to make a complaint and we saw the service recorded and investigated complaints appropriately. There was a complaints policy and procedure in place.

At the last inspection we discussed end of life care with the manager. They told us these discussions were held with people, their relatives and GPs.

Insufficient improvements had been to quality assurance and improvements systems. For example, we identified gaps in audit processes and we found no record of 'lessons learnt' from accidents and incidents that had taken place within the service. This was a continued breach of the relevant regulation and meant the provider did not have adequate oversight of the quality of care provided.

The service conspicuously displayed its most recent performance rating within the home. We noted the provider was open and honest to people and their relatives about the service's recent performance and held a meeting to discuss the outcome of the previous inspection (April 2017) and how they would improve the service provision.

We observed the culture of the service to be relaxed and welcoming. People knew who the manager was and engaged well with them. The manager was 'hands-on', friendly and approachable. Staff told us both the manager and deputy manager were helpful and supportive.

The overall rating for this service is 'Inadequate' and the service remains 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.

Recruitment processes were not sufficiently robust and did not provide adequate assurances that appropriate care staff were employed.

People were put at risk because the provider did not ensure all appropriate action was taken in areas such as fire safety equipment and infection prevention.

Medicines were not managed in a safe way. Audit processes did not identify the issues we found at inspection

Is the service effective?

Requires Improvement

The service was not consistently effective.

Consent to care was not always sought appropriately.

Induction process was not robust, and mandatory and on-going training required improvement. Several staff had not completed training in key subject areas such as dementia awareness and moving and handling.

People were able to access relevant healthcare professionals. These included GPs, dentists and specialist mental health practitioners as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

There was insufficient evidence to demonstrate that the service was a caring organisation.

People were treated with kindness. We observed good humoured interactions between people and staff.

The atmosphere at the home was comfortable and relaxed. Staff knew people well.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There had been some improvement in activities provided.

Care plans reflected people's individual needs and included personal histories, interests and hobbies.

Complaints were recorded and investigated in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not well led.

Insufficient improvements to how the service was managed had not been made since our last inspection. Quality assurance processes in place were not sufficiently robust to identify where improvements were required.

There were staff meetings which provided the opportunity to discuss service related matters.

People knew who the manager was and engaged well with them. Staff told us they enjoyed working at the service and that management was supportive.

Derby House

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 28 and 29 November 2017 and the first day was unannounced. The inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance, the expert by experience had expertise in dementia care.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) of 'Is the service safe, effective, responsive and well-led' to at least 'Good'. We found we found that insufficient improvements had been made following our previous inspection. We identified continuing breaches in the Health and Social Care Act regulations relating to medication management, recruitment practices, staffing training, consent to care and governance systems.

Prior to our site visit, we looked at information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We had also received the most recent infection control audit undertaken by the local authority infection control lead November 2017.

Following our inspection visit to the service, we asked the local authority contracts, commissioning and safeguarding teams. They told us their recent monitoring visits had identified several areas that still required improvement and that they had been working closely with the staff and management to support the service's improvement. We also contacted Healthwatch but they did not have any information about this service. Healthwatch is an organisation responsible for ensuring the voice of users of health and care services are heard by those commissioning, delivering and regulating services. Details of information provided by the local authority are contained within the report.

We did not ask the provider to complete a Provider Information Return (PIR) as one had been completed in

April 2017. The PIR 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.

We spoke with four people, the manager and four care staff. We observed the way people were supported in communal areas and looked at records relating to the service, including three care records, daily record notes, medication administration records (MAR), three staff recruitment files and policies and procedures.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at Derby House and if they had concerns about their safety they would speak with staff. Their comments included: "I'm all right. They look after me well. I haven't any big worries. If I had I'd speak to the staff" and "The staff don't bully me; other residents don't bother me". Our observations during our inspection visit confirmed what people told us.

At the previous inspection in April 2017, we found breaches of the regulation relating to the safe recruitment of staff. At this inspection we found little improvement had been made in this regard. For example, we reviewed the personnel files for four newly recruited staff and found references had not been received or were unsuitable, unexplained gaps in employment history and evidence that staff started prior to the completion of Disclosure and Barring Scheme (DBS) checks. The DBS keeps a record of criminal convictions and cautions which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups.

The concerns we identified meant the recruitment process did not provide robust assurances that adequate pre-employment checks had been completed and suitable staff employed. This was a continued breach of Regulation 19(1)(a) and 19(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection April 2017, we found there were inadequate systems and checks in place to ensure people's safety. This was a breach of the regulations relating to good governance. At this inspection, we noted some improvement had been made. For example, we saw the provider had a regular system of carrying out checks of fire safety equipment and emergency lighting. However the provider did not sufficiently demonstrate inspection we noted some improvements had been made but not provide sufficient assurances that there were adequate systems in place to ensure people's protection and safety. We noted doors were still being wedged open with wooden blocks and fire drills were not carried out regularly as recommended in the fire risk assessment.

Failure to ensure systems and measures in place were used correctly and that appropriate equipment was installed such as door guards meant that people's safety and wellbeing were not protected. This was a continued breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In April 2017, the service was in breach of the regulations relating to the safe administration of medicines. At this inspection, we noted the provider had made the following improvements: implementation of a specimen signature list, daily recording of fridge temperatures and controlled drugs storage and recording. Controlled drugs are medicines where strict legal controls are imposed to prevent them from being misused, obtained illegally or causing harm. However we found aspects of medicines management that were not safe. For example, we observed one member of staff signed the medication administration record (MAR) before giving the person their medication. This was not safe practice as we could not be sure the person had taken their medication. We found discrepancies between the remaining stock and what was recorded on the

MAR. We saw no audit record to indicate these errors had been identified. The provider failed to ensure adequate systems were in place to help ensure medicines were managed safely and staff suitably competent. This was a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in April 2017, we found the provider was in breach of the regulations relating to infection control and prevention. Prior to this inspection we had sight of the infection control audit carried by the local authority infection control lead on 1 November 2017. The home's rating had improved from red (low compliance and needing urgent) to yellow (medium compliance, further consideration and actions needed). We noted three actions in relation to the lack of suitable facilities for the decontamination of domestic cleaning equipment and bed/commode pans were identified as priority areas. The manager told us one of these would be completed after Christmas 2017 but did not specify an exact time frame. This meant people living at Derby House were at risk because appropriate action to prevent the spread of infection was not taken. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we noted risks were not always managed in a consistent and safe way. We saw moving and handling risk assessments and management plans in place did not contain sufficient details to minimise the risk to people when using the stairs. At that time, the provider told us they would make improvements to these documents. At our inspection in November 2017, we saw there had been no change. For example, there were no specific details as to exactly how staff were to support a person at risk of falls to mobilise from one place to the next or to support them in the shower or bath. This meant people were not sufficiently safeguarded from harm because staff did not know what specific action they should take to protect people's wellbeing.

We looked at risks in respect of mental health and cognition and saw that assessments contained sufficient information to help staff manage behaviours that might challenge in a safe way.

The provider kept a record of accidents and incidents included falls that took place in the service and the actions taken. These incidents were also recorded in people's care files. Action taken by the manager, if applicable, was recorded on the incident and accident forms. We noted however not all of the incidents we had seen in people's individual care records had not been recorded in the accidents and incident records. This meant the provider did not have full oversight of incidents nor did we see that the provider had done any analysis or identified any trends.

We observed how staff supported people throughout our inspection and looked at staffing rotas. We saw there were two staff on duty during the day and one member of staff on during the night. There was also a sleep in member of staff available at the sister home next door should additional support be needed. The provider and deputy manager alternated their provision of 'on call' support. The manager also lived on the premises and was available should an emergency arise.

We asked people if there were enough staff to look after them in a safe way and most people told us they thought there was. One person told us, "It's not bad; it's reasonable." Another said, "They (the manager) move staff from the other home next door if they need." No one we spoke with had serious complaints about response times to calls for help. We noted some residents used buzzers to alert staff when they needed help and others simply shouted.

Records indicated the home sometimes used an agency staff member to cover shifts. Rotas and staff we spoke with confirmed regular agency staff worked at Derby House. This helped to ensure a consistent staff

team. From our observations we found that sufficient number of staff were available and responded to people's requests promptly.

Staff we spoke with could identify the types of abuse and were able to tell us what action they would take to help ensure people were safe. There was an up to date policy and procedure in place to guide staff in safeguarding people from harm. Training records confirmed some staff had received training in safeguarding. From the provider's training matrix, we noted that 50 per cent of staff, including two new recruits had not completed safeguarding training. This meant that people may be put at risk because staff lacked the necessary knowledge and understanding of what abuse was and their responsibility in reporting these concerns. This was an area for improvement which we identified to provider at our last inspection. We have discussed this lack of training later in this report.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 previous inspection in April 2017, we found the service was not meeting the regulations. At this inspection, we noted the provider had not made sufficient improvements to ensure consent to care was sought appropriately. In one of the care plans we reviewed, we noted a relative of the person acted on their behalf. However, there were no records to show they had the legal authorisation, such as lasting power of attorney (LPA), to make decisions on behalf of the person. An LPA is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf if they are unable to do so.

The service maintained a record of DoLS applications made to the local authority. At the inspection, we identified two DoLS authorisations had expired on 12 and 13 October 2017 and had not been renewed. This meant people were being unlawfully deprived of their liberty. We brought this to the manager's attention and they showed us an email to the local authority dated 31 October 2017 requesting that these DoLS authorisations be renewed.

Staff we spoke with had varying understanding and knowledge of MCA and DoLS procedures. The training records identified three of 24 staff employed had completed MCA training. We noted the local authority in their recent monitoring and support visits had identified and recommended the provider seek training for staff in this area. This training should help staff to understand where a person lacks the mental capacity and is deprived of their liberty, they will need special protection to make sure their rights are safeguarded.

Failure to ensure appropriate systems were in place to help ensure people's rights were protected was a continuing breach of Regulation 11 (1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In April 2017, we found the provider had not ensured staff received adequate training and support to carry out their role. This was a breach of the regulation relating to staffing. At this inspection we found the provider had not made sufficient improvements in this area. For example, the induction programme was not sufficiently robust and mandatory and ongoing training were not consistently completed.

Staff we spoke with said they had received supervisions, and where relevant, appraisals. However, from the provider's records, we identified staff members who had not had supervision or an appraisal in 2017.

Failure to provide relevant ongoing training and professional support to staff so that they functioned effectively in their roles was a continuing breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care plans for three people living at Derby House. We saw that the provider carried out an initial assessment prior to admission which identified the specifics of care and support the person needed. This helped to ensure the service was suited to the person's assessed needs. Care plans considered various aspects of the support people needed including mobility and dexterity, medication, foot care and dental needs, mental health and diet and weight. Care plans contained good details around the level and type of support needed, for example, support from one or two staff members and the actions staff should take if a person became agitated. We observed that staff knew people's assessed needs and were able to either distract or calm people when they became agitated. In one person's care records we saw a guidance document which provided further information on their particular condition and strategies to manage their behaviours.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their dietary needs were met. Care staff were responsible for cooking the meals in a large domestic kitchen. The service operated a four weekly menu which showed what meals were provided for lunch and tea time meal only. Similar to what we found at the last inspection in April 2017, some of the menu information was limited. For example, 'baked potatoes' and 'gammon' with no reference to what these would be served with. However additional information was recorded in the food diaries completed for each person. We noted the introduction of a menu chalkboard situated on the wall above the dining table. However, the handwritten information displayed on the board was small which meant people with a visual impairment would not be able to read the menu options.

The general consensus from people about the food was that the quality was acceptable. One person thought the food was "good". Another person said, "It's (the food) not too bad but you can't choose." A third person said, "The menu choices are poor (and) young staff who can't cook." People also told us if they did not want the meal on offer they would ask staff and an alternative meal would be provided. We observed this was the case.

We observed breakfast and lunch on the two days of our inspection visit. Breakfast choices were limited to toast and marmalade, Weetabix and porridge and a hot drink of choice. No one was offered fruit or fruit juice. Care records we looked at did not always contain specific details about people's food preferences so we were unable to corroborate if all food on offer was based on personal choice. Regarding the catering provision at the home, we noted both relatives who responded to the satisfaction survey in August 2017 had made suggestions on how the service could improve in this area. They said staff's cooking skills could be improved and that the home could serve more homemade traditional meals and offer fresh fruit. We did not see evidence of how or when the service intended to action these suggestions.

We saw the home maintained records in relation to people's weight. This helped the service respond promptly to people's changing needs. We noted inconsistency in the system of measurements used. For example, we saw some staff recorded weight using stones and pounds and other used kilograms. We saw these records were not always completed fully to be able to calculate a person's body mass index (BMI).

The last food hygiene inspection had been done in August 2016 and that the home had been rated a '4' out

of '5' (5 being the highest rating).

We saw that in most cases the home facilitated people's access to health care professionals. These included GPs, dentists and podiatrists. We saw that referrals to appropriate services such as speech and language therapy and CPNs were made as required. Care records we looked at confirmed this. One person we spoke with told us the home had cancelled their foot care appointment twice. We discussed this with the provider who told us the appointment had been cancelled because the service was unable to support the person to the appointment. We pointed out their decision had not been adequately communicated to the person and that this had caused the person some distress. The manager acknowledged this and showed us, prior to our visit, that a new appointment had been made with the person's consent and suitable transport arrangements. We concluded that while some people had been provided with the right healthcare when they required this other people may not always necessarily have had that same courtesy.

Derby House is a large detached house which provides accommodation and support for up to seven people. There are three bedrooms on the ground floor and four bedrooms on the first floor, accessible by stairs or a stair lift. All bedroom benefit from en-suite bathroom facilities. People's rooms were personalised with their own belongings from home. There is a large and accessible open plan lounge, dining room and kitchen. Corridors were sufficiently wide for people who used mobility aids such as walkers.

We found the environment was suited to people living with dementia. The decorations, soft furnishings, carpets and curtains throughout the home were plain and free of 'busy' patterns. Communal bathrooms and toilets had large signs with both words and pictures. People's bedroom doors were numbered and each had a recent photograph of the person. While these measures helped to ensure people were able to orientate themselves within the home, it is common for some people living with dementia to not recognise themselves in recent photographs. We recommend that the provider reviews best practice guidance on dementia friendly environments.

Requires Improvement

Is the service caring?

Our findings

Throughout our inspection, we witnessed many good interactions between people and staff which were kind and good humoured. It was evident that staff knew people well. Staff we spoke with were able to tell us about the people that lived at Derby House, their personalities and their preferences. Care plans we looked at confirmed what they told us. Staff's approach was calm and caring and they carried out their work according to the pace of the person they were attending to. In a recent satisfaction survey we saw one relative wrote, "(The home) understands the needs of the client (well)."

We observed, for the most part, interactions between the people living at the service were good. We saw one person helping staff to calm another person when they became agitated.

On both days of our inspection we saw that people got up in the morning and retired at night when they wished. Daily routines were flexible and people chose where they spent their time, either in their rooms or in the communal lounge.

Staff told us they kept each other informed of people's current and changing needs during shift handovers. Handovers involved all staff on duty so that they were aware of any areas of work that needed to be completed or appointments attended. There was also a staff communication book in which key issues discussed recorded. We observed a staff handover during our inspection. This helped to ensure people receive the support needed so their health and well-being was maintained.

All the residents we spoke with said staff treated them with respect and dignity. One person told us staff always knocked on their door before entering. However, whilst speaking with one person, we observed a staff member on several occasions entered the room without knocking. We told the manager about this incident and they told us they would address it with the staff member. We also observed a person being assisted out their wheelchair into a chair. Throughout the transfer, staff explained what they were doing, supported the person at their own pace and constantly checked their welfare.

Everyone we spoke with told us staff helped them retain their independence as far as possible and encouraged them to do as much as they could themselves. One person told us, ""I have to have some help, but I can wash myself." Three people were able to mobilise using walking aids and we observed staff gently encouraged people to maintain their mobility. We saw staff were always on hand to help ensure they safely moved from one location to the next. This showed us staff understood the importance of taking time to involve the person and promote their independence.

We acknowledge staff's interactions with people to be caring. However due to insufficient progress with improvement work we found the provider had not sufficiently demonstrated the hallmarks of a caring organisation.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in April 2017, we noted there was not much meaningful activity taking place throughout the day which was suited to the people living at Derby House. Meaningful activity and/or occupation is important to help maintain good wellbeing. We discussed with the manager at the time that this was an area that required improvement. At this inspection we noted some initial improvements had been made.

We asked people how they spent their time and if they got involved in any activities. Some people told us there "was nothing much" to do or they "watched television". Other comments included: "We play games sometimes. Go out, not often. Go to see local people or the shops, no often, just now and again", "We used to have someone come and play music but you had to pay £5 a go. You can have your nails polished but you have to pay for the polish", "We don't have any trips" and "I read a book or walk around."

We asked people if there were any activities they would like to do which they did not do at present. One person told us, "I'd like to go to the park."

We saw the home had a few board games and mid-afternoon on both days of our inspection we saw staff members engaging those residents who wished to participate in various games. We also observed one person enjoyed helping staff in the kitchen by doing the washing up and wiping the counters, for example. From minutes of the family meeting in September 2017, we noted the home had an arrangement with a local school to visit and entertain residents. This had started in September 2017. From a letter to relatives dated October 2017 we saw the manager gave an update on upcoming activities for the period November to December 2017. These ranged from weekly visits from police cadets and an exercise class.

Given the small size of the home, there was no dedicated activities coordinator. However the provider told us one of the staff had taken on added responsibility in this area. We spoke with this staff member about how they arranged activities for the home. They showed us a list of activities for November 2017 that had been developed based on people's preferred activities. The staff member was quite passionate about getting people involved in meaningful activities and expressed their frustration when other staff "don't do their part (to encourage activities) and just make people cups of tea and think that's enough". We saw they kept a record of what activities had been done and what worked well and what did not to help plan future activities. This should help the service ensure that people were engaged in suitable activity that was meaningful and stimulating.

Care plans we looked at reflected people's physical, mental, emotional and social needs and included a personal history, interests and hobbies and religious practices. From all care plans we reviewed, we saw that people and their relatives were involved and contributed to the care planning process. People's communication needs were identified and recorded. This helped the service respond appropriately to their needs. For example, in one person's care records we saw they required additional support as a result of their dementia. We noted several proactive interventions the service had arranged to ensure the person received the necessary support to manage their dementia. This included the involvement of the GP and the

community psychiatric nurse as necessary.

We noted not all aspects of people's history and interests/hobbies had been completed. For example, in one person's care plan we noted gaps in information about where they were born, family information and how long they worked in their previous occupation. We asked the manager about this. They told us this person was very private and chose not to disclose this information. We pointed out that this had not been recorded within the care plan.

We checked to see how the service managed concerns and complaints. All but one person had had no cause to make any complaints but told us they would speak with staff if they had. One person said, "If I wanted to complain I would ask the manager or the deputy to come and see me." Another said, "I've no reason to complain. We saw that one complaint had been made. Records showed the concern had been investigated and resolved appropriately.

We saw the home had received two compliments from students who were on work experience placement. They said they found the staff to be "a good team - supportive and helpful".

At the last inspection we discussed end of life care and advanced care preferences with the manager. They told us these discussions were held with people, their relatives and GPs. However we did not see end of life care provisions within people's care plans. At this inspection we saw in the minutes of a relatives meeting in September 2017, the manager again discussed the benefits of end of life and advance care planning to help ensure people's final wishes were noted and acted upon when required.

Inadequate

Is the service well-led?

Our findings

At the last inspection in April 2017 we found the service was not well led and we identified breaches of the regulation in relation to good governance. At this inspection we checked to see what improvements had been made. We found insufficient improvements had been made in several areas across the entire service and there was a continued breach of the regulation in relation to good governance.

There were some quality checks such as care plan and medication audits. However these were not sufficiently robust and did not address the concerns we identified at our inspection or demonstrate what remedial action had been taken. These included medication errors, discrepancies in how risks were recorded in care plans, inappropriate consent, gaps in on-going training, supervision and appraisals, inconsistent recording of accidents and incidents and poor record keeping. This meant the provider did not have sufficiently robust systems in place to help ensure the quality of the service was well monitored and to make the improvements from lessons learnt in a proactive manner. This was a continued breach of the Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of the provider's improvement work, we noted the delegation of some responsibilities to senior staff in areas such as activities and fire safety monitoring. These responsibilities had only been recently implemented (in October 2017) so we were unable to assess how effective staff were in these new roles.

Following our site visit, we asked the local authority to provide feedback about their involvement with the home. The local authority contracts monitoring officer told us some improvements had been made such as in infection control and prevention, increased family meetings and more regular staff meetings. However they identified other areas that required further improvement and had made recommendations to the provider. Areas identified included mental capacity and DoLS, training, supervisions, activities and audit processes. As discussed, our inspection also identified these gaps.

The provider told us and we saw a satisfaction survey had been sent in August 2017 to people and their relatives. The provider maintained however that due to the small size of the service people and their relatives did not have to wait to complete an annual survey to make suggestions about the service provided. Two out of seven surveys were returned. Comments in the main were positive and we saw relatives identified what the home did well and where improvements were required. We did not see that the provider had developed an action plan to address comments made by relatives. However we saw that some actions such as improved activities and the display of menus had already been taken.

We saw that staff meetings were held in July 2017 and October 2017. The manager told us the next staff meeting was scheduled for early December 2017. It is important that staff are given the opportunity to highlight and discuss service related matters with their colleagues and management. Minutes of meetings showed that detailed discussion of people's individual care and support needs took place as well as operational issues like fire drills and medication administration. We noted from the minutes that staff participation was good and that they were encouraged to and made suggestions about how the service could be improved – suggestion box, regular family meetings and newsletters.

With regards to the registration of this service, there is no condition that the provider must employ a registered manager. As such the provider managed the day to day responsibility of running of the care home. The provider was supported by a deputy manager who also worked across both of the services.

We saw the service displayed its most recent performance rating of 'Inadequate' conspicuously in the entrance hallway. Following the inspection in April 2017, the provider held a meeting with relatives in July 2017 to discuss the outcome of the inspection and to provide a forum for relatives to ask questions about the inspection findings and give their feedback on how the service could make improvements. We saw minutes which confirmed this meeting had taken place. We acknowledged the provider demonstrated integrity and openness in chairing this process however at this inspection we found some of the improvements mentioned within the minutes such as recruitment processes and the safe management of medicines had not yet been embedded in practice.

From our observations we saw the day-to-day culture of the service was relaxed. People living at Derby House knew who the manager was and engaged well with them. The manager was visible in the service and we observed them to be approachable and friendly. Staff told us they enjoyed working at the service and that both the manager and the deputy manager were very supportive.

The provider maintained a number of policies and procedures to provide guidance to staff on various operational responsibilities and were accessible to staff. These included a code of conduct, safeguarding and medication. These documents helped to ensure that all staff had updated information that reflected current legislation and guidance.

The registered provider ensured statutory notifications were completed and sent to Care Quality Commission (CQC) in accordance with legal requirements. Services providing regulated activities have a statutory duty to report certain incidents and accidents to the CQC.

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 11 HSCA RA Regulations 2014 Need for consent The rights of vulnerable people were not adequately protected in line with legal requirements because the provider failed to implement appropriate systems. Reg 11(1),(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People living at Derby House were at risk of infection because remedial action previously identified had not been taken. Reg 12(1)(2)(h) People were put at risk because their medicines were not managed safely and not all staff were suitably competent to administer medicines. 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were at risk of harm because the provider did not have sufficiently robust systems in place to effectively monitor the quality of the service and to make required improvements in a proactive manner. Reg 17(1)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were put at risk because the provider did not carrying out adequate pre-employment checks to help ensure suitable staff were employed. Reg 19(1),(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were at risk of harm because staff did not receive relevant training and professional support to help them function effectively in their roles. Reg 18(2)