Delphine Homecare Limited

Annabel House Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Annabel House Care Centre provides accommodation for people who require nursing and personal care for up to 32 people. On the day of inspection there were 18 people living at the home; one of whom was receiving temporary respite. Most residents were living with dementia and were unable to effectively communicate with us. The accommodation is arranged in one building over two floors.

This inspection was unannounced and took place on the 15 and 17 July 2015

The home has signed up to the Butterfly Project in conjunction with Dementia Care Matters. This is an approach of working with people with dementia where you accept the world as they see it. Staff did not wear uniforms and positive interactions with the people are encouraged. There are four lounges set up for different stages of dementia.

There is a registered manager who is supported by a clinical lead nurse. A registered manager is a person who has been registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

Although some people told us that they felt safe, there were risks to their safety. Since the last inspection there had been improvements with the hot water, radiator covers and the boiler was now in a cupboard. However, there were still concerns about environmental hazards such as wheelchairs and hoists being left insecure.

Most staff were aware of their responsibility to protect people from avoidable harm or abuse, but some had not received up to date training. Staff knew what action to take if they were concerned about the safety or welfare of an individual. They told us they would be confident reporting any concerns to a senior person in the home and they knew who to contact externally. However, most staff were unclear on what constituted a restraint or how to safely break away from a person.

The medication processes in the home were good and the recruitment process followed good practice. Generally the home was clean but there were some minor areas for improvement.

The staff received some training, but not all staff had received dementia training. There was limited understanding of how to support people who lacked capacity to make decisions for themselves. Staff supported people to see other professionals to help with their care. Staff supported and respected the choices made by the people.

People had a choice of meals, snacks and drinks, which they told us they enjoyed. The chef worked hard to ensure that they met people's preferences. They provided alternative options if the people did not want what was on the menu.

People and their relatives thought the staff were kind and caring. We observed some positive interactions, but occasionally this was not the case. The privacy and dignity of most people was respected. People were encouraged to make choices throughout their day.

There were detailed care plans for all individuals but most of the staff had not read them. The needs of the people were not met when care was being delivered.

People knew how to complain and there were systems in place to manage the complaints.

Since the last inspection the registered manager had put some quality assurance procedures in place. The audits were not consistently completed or used by the registered manager to ensure the health and safety of people using the service. Care records were not stored appropriately.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering the action we will be taking.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Staff did not understand how to keep people safe from harm around restraints.

Most staff understood how to keep people safe and who to tell if they had concerns around safeguarding people. There were enough staff to meet the needs of the people that used the service.

People's medication was stored and administered correctly.

Requires improvement

Is the service effective?
The service was not always effective.

People were not always supported by staff that had appropriate and up to date training.

The registered manager and some staff had some understanding of how to make best interest decisions on behalf of someone who did not have capacity.

Most people were supported appropriately to eat and drink. People were supported to see other health and social care professionals.

Requires improvement

Is the service caring?
This service was not always caring.

People told us that they were well looked after and we saw that the staff were mainly caring but there were interactions that were less positive for people.

People were involved in making some basic choices about their care.

Most people's privacy and dignity was respected.

Requires improvement

Is the service responsive?
The service was not responsive

People did not always receive the care and support they required because staff were not familiar with people's individual care plans

Care was not being delivered in line with the care plans and people were put at risk.

People knew how to make complaints and there was a complaints system in place.

Requires improvement

Is the service well-led?
The service was not well-led.

The service had some audits in place but these were not used to ensure the health and safety of the people.

Inadequate

Summary of findings

The registered manager had not identified all the risks to people around the home.

There was a strong presence of management around the home and they promoted a specific approach to support people with dementia in the home.

Annabel House Care 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 15 and 17 July 2015 and was unannounced. It was carried out by one inspector, one specialist advisor nurse with dementia training 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 for people with dementia. We were following up on previous outstanding regulations that the provider had not met at our last inspection in January 2015. We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with people that lived at the home. We spoke with the registered manager and twelve staff members, including two registered nurses. We spoke with three visitors and an Independent Mental Capacity Advocate (IMCA). An IMCA is someone that is employed to act on behalf of a person to make big decisions where they do not have capacity. We spoke with five health and social care professionals on the telephone.

We looked at six people's care records and observed care and support in communal areas. We looked at eight staff files, the providers action plan, previous inspection reports, rotas, quality assurance audits, the home's training matrix and supervision record, the home's statement of purpose, the terms and conditions document and a selection of the provider's policies.

Requires improvement

Is the service safe?

Our findings

At the last inspection the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They were in breach because the auditing systems were not robust and the risks to people's health had not been identified. This included the risk of hot surfaces and hot water from hand wash basins.

Following the last inspection in January 2015 we requested the provider send us an action plan to outline actions they would take to improve the service and ensure it met requirements of the regulations. The provider sent us their action plan on 28 April 2015, which stated the service would be compliant with the regulations by 27 April 2015. At this inspection, we found that the provider had not met all the improvements in their action plan.

At the last inspection there were concerns around the safety of the home. We saw improvements had been made. The hand wash basins had water that was not too hot to touch and a hot water boiler that was previously exposed was now housed in a domestic cupboard. Radiators now had covers to protect people. However, they had not regularly completed environmental audits to monitor the risk to people.

At the last inspection there was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was insufficient staff to meet people's needs safely particularly at key times of the day. Action has been taken as a result the home is no longer in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been improvements since the last inspection in the staffing levels at the home. Throughout the two days we observed people's needs being met. One person said "I had a nightmare last night and rolled out of bed; I called for help and they came and put me back to bed." A visitor we spoke to explained that now there were less people living at the home there were enough staff. The members of staff we spoke with all thought the staff levels were better than before. One staff member said "Yes always! We occasionally replace staff off sick with agency" when asked if the level of staffing was adequate. Another member of staff said "Since last inspection staffing has been better." We looked at four weeks rotas that demonstrated a consistent level of staff in line with the level the registered manager said was required.

At the last inspection there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all staff had received up to date training in safeguarding vulnerable adults. There were concerns about people's safety and these concerns had not been clearly identified and properly investigated.

Since the last inspection there had been improvements. One person said "I feel safe and secure here." Social care professionals complimented the registered manager on their openness to report issues that they felt were safeguarding. One member of staff had raised their concerns with the registered manager in relation to an incident they had witnessed. The process was followed correctly by the registered manager to investigate this concern and the records were clear.

The safeguarding policy had been rewritten by the registered manager and reviewed by the local authority to make sure it was in line with their procedures. There was information about safeguarding in a number of areas around the home including the staff room and the entrance. In the care plans there were body maps used to record marks and wounds and pressure sores on people. This meant they were effectively monitoring people's health.

Most staff had up to date training in safeguarding. However, we spoke with a member of staff and were told they had not had safeguarding training since 2013 and the training matrix confirmed this. The training records showed six members of staff had not received safeguarding training in the last year. So not all members of staff would be aware of recent changes in legislation.

Members of staff we spoke to, including the registered manager, were not clear what constituted a restraint. The registered manager demonstrated different ways of holding a person's arm whilst doing personal care and only considered one way of holding as being a restraint. One

Requires improvement

Is the service safe?

member of staff explained that they had not seen restraints used but had seen breakaway techniques. Another member of staff said "There are times when restraint is used". We were told there was no training on breakaway or restraint for staff. This meant people were at risk of techniques being used incorrectly by members of staff which could potentially result in harm to the person.

At the last inspection there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some people were prescribed medicines to be taken 'as required'. There were no written protocols in place to ensure these medicines were administered consistently and as directed by the prescriber. Full instructions of the application of topical creams were not always stated, increasing the risk of error. This is no longer in breach.

We saw there had been improvements in the management of medication. There was a policy in place for the storage and administration of medicines. All of the medicines, including controlled drugs, were stored correctly in locked cupboards with the keys held by the duty nurse. The recording systems were correctly completed. Audits were completed by the clinical lead and the last one was dated 10 May 2015. This meant the clinical lead was monitoring the medication to keep people safe. There were protocols in place to make sure people received 'as required' medicines safely. As a result the home had met this regulation.

We identified risks to people's safety because wheelchairs and hoists were being stored in corridors without being safely secured. This meant people who were unsteady on their feet were at risk of grabbing objects that would move whilst walking around the home.

We observed people were transferred safely using various pieces of equipment including hoists and slings to support people's feet. People were given explanation and reassurance whilst being moved from an armchair to a wheelchair and from a chair in their bedroom to the lounge. The nurses were responsible for updating the moving and handling risk assessments; this ensured risks had been considered to people.

People had Personal Emergency Evacuation Plans to make sure they could safely be evacuated in an emergency. These plans identified the correct way to help someone during an evacuation. They contained details, including instructions for identifying where in the home the person was and the nearest place of safety. Some of these plans needed reviewing because they contained incorrect information about which bedroom the person was in.

Risks of abuse to people were minimised because there was a robust recruitment process in place. These included at least two reference checks from previous employers and checks had been carried out to ensure that staff had no criminal convictions and were safe to work with vulnerable adults.

On both days of the inspection the home was generally clean. During the inspection there were full laundry baskets with mixed clothes found in various places including bathrooms. We raised this with the registered manager and saw the laundry had been removed. After meals the tables were not always cleaned which meant food debris was left; later the same tables were used for activities. This meant improvements were needed to ensure people's hygiene was maintained.

We recommend the provider source National Guidance and review their policy and staff training around restraint

Requires improvement

Is the service effective?

Our findings

At the last inspection there was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not consistently receive up to date training to undertake their role effectively. Whilst staff said they felt supported, formal systems such as supervision and appraisal were not routinely taking place. The provider sent us an action plan which detailed the action they would take to address these shortfalls and said this would be in place by April 2015.

Since the last inspection there had been some improvements in staff training and supervision. When we arrived the registered manager was in the process of auditing the training and supervision records. Staff said that they had received a variety of training and most of this had been delivered through online courses. There was a training matrix in place that highlighted training that had not occurred or needed refreshing. But there was nothing in place to show planned training. Therefore, the needs of the staff had not been identified effectively to ensure the best care for the people.

The provider's action plan stated "All staff have received appraisals and all staff have received supervision". Supervision is put in place to support the staff in their learning and development and ensure they have the appropriate skills to support people. The member of staff and supervisor had a way to formally discuss any positives and concerns to their work. The registered manager, staff and supervision policy stated that supervision occurred every three months. The registered manager showed us the supervision record and said it was up to date. The supervision matrix showed that three members of staff had not received supervision in the last three months. This meant they had not met their action plan and their own policy and procedures had not been followed. As a result staff had not received appropriate supervision necessary to enable them to carry out their duties. The registered manager said that they had been on annual leave at the end of June 2015. This meant that staff were not always supported effectively and the quality of care they provide is not monitored.

One member of staff was a manual handling trainer whose role was to train staff to ensure people were moved safely. We spoke to the trainer who stated a member of staff should not participate in manual handling until they had received training. However, a member of staff said they had not received training since starting work at the home, but had used the hoists because they were the same as where they used to work. On the training matrix there were no records that this person had received manual handling training. The registered manager said that this staff member had manual handling training from their previous employment. The staff file had no completed induction or moving and handling assessment. This meant there was no system in place to ensure previous training of staff was up to date. This placed people at risk of being moved inappropriately.

Most of the residents in the home had a form of dementia. A social care professional said it was important staff received basic dementia training to meet the needs of people. One staff member did not believe that a person had dementia despite their diagnosis. The reason given by the staff member was "Because (they) understand what you say and is just so horrible, sometimes". The training matrix showed 10 staff had not received basic dementia training. This means that not all staff had the skills and knowledge to effectively support people who lived with dementia.

As a result, this is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection there was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns about the nutritional intake of the food people received. Not all people were supported to eat in a way which met their needs. A record of people's food intake was maintained but alternative or further encouragement to eat following refusal was not in place.

Since the last inspection there had been improvements. The home had a new chef who had a list of people's likes and dislikes. There were drinks available for all residents throughout both days. The food appeared well presented and portion sizes were appropriate. If a person did not like what was on offer, the staff asked the cook for an alternative such as sandwiches. One person said they ate better now than they had ever done in their life. Other

Requires improvement

Is the service effective?

comments from people included “Food is great, lovely cook”, “Food is lovely”, “Food seems good” and “Food is alright”. Some people required assistance at mealtimes. We saw these people were supported to eat their meal and had appropriate equipment to assist them, for example a plate guard. Staff were attentive throughout the meal times and those who could eat independently were checked to ensure they did not need any support.

CQC is required by law to monitor the operation of Deprivation of Liberty (DoLS). The Mental Capacity Act (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. DoLS are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken and these best interest decisions are recorded. We discussed the MCA and DoLS with the registered manager and staff. The registered manager had a good knowledge of the MCA and DoLS and had been completing DoLS applications for people that required them within the home. They ensured an Independent Mental Capacity Advocate (IMCA) was used when required. This is an individual who acts on behalf of a person to make important decisions when they lack capacity and have no other person such as a relative to speak on their behalf.

We asked some members of staff about their understanding of MCA and DoLS. One said “I don’t know what that is”. Another, who had received training in May 2015 on DoLS, was unable to explain what it was. A third member of staff said “Mental Capacity is where they (the people) can’t make a choice for themselves” but was unable to explain what ‘best interest’ meant. The training matrix confirmed some care staff had out of date or no training in MCA and DoLS. Members of staff told us that there were a number of people who did not have capacity for most decisions due to their level of dementia.

Care plans lacked evidence of capacity assessments and best interest decisions for people. For example, one person’s care plan showed there was a DoLS but no other capacity assessments or best interest decision had been completed. Another person had a DoLS in place and one capacity assessment completed by a local authority nurse dated 2012; there were no other capacity or best interest records. Following the inspection one more MCA and best interest decision was shared with us for this person. We spoke to the registered manager who said that they were not sure how to document this information. This meant the provider failed to ensure care was delivered with the consent of people who lived at the home. Additionally, the provider failed to act in accordance with the MCA and had not protected people’s human rights.

People had their health needs monitored and had access to other health care professionals. One person said “I can see my doctor if I need to.” The doctor visited regularly to see people and manage any health changes required. Two people told us they had been visited by their social worker to discuss their care needs for a review. A relative said staff had called a doctor when their loved one had fallen and the provider had taken the appropriate action and had accompanied the person to hospital. The provider took action when specific health needs had been identified for people. For example, one person had recently been assessed by the Mental Health Team. Care plans confirmed people had been referred to a range of care professionals to support their individual needs.

We recommend that the service seek advice and guidance from a reputable source about the application of the MCA Code of Practice and DOLS to residential care services.

Requires improvement

Is the service caring?

Our findings

A member of staff referred to a person as a "Good girl" as though they were a child when they had finished their lunch. This did not show this person respect. On three separate occasions a person with mobility issues was given a drink balancing on the arm of their chair; it was knocked off each time. There were small tables nearby that could have been used. However, staff did joke with them about it and helped to clear it up quickly. Following the inspection we were told the person has limited mobility. Therefore, a drink is placed on the arm of the chair to maintain as much independence as possible.

People felt staff were caring. One person said "Staff are really kind and are always there to help. I get on well with all staff, we have a great relationship, they keep me informed of what is going on and I have never been upset about anything." Other people who were able to speak with us agreed that staff were kind. One said "Staff were very nice, very kind, very good, nothing I lack." Another person said the staff were "Very good girls, they help me when I need it, they are pleasant, no rushing.

The majority of visitors we spoke with thought staff were respectful and kind. However one visitor felt staff did not understand their loved one's condition and so had unrealistic expectations about why the person would not comply; this had made the their loved one upset.

We observed positive interactions between the staff and the residents. The staff were attentive to the needs of the people. For example, a member of staff covered a person whose clothing had become unbuttoned. Two members of staff wrapped another person in blankets after the person had removed all their clothes before escorting them to their bedroom.

We spoke to staff who understood the importance of being caring. One staff member said caring is "Being there for them when they need it most." Another staff member said it is "Providing for our client's needs, whatever they need."

Staff were polite and acknowledged people when they initiated interaction with them. They spent time listening and responding to people. Part of the Butterfly Project was to interact with people about what they chose to talk about including their past and we saw staff doing this. People were smiling and calm in response to the care staff.

People were encouraged to make choices. These included where they would like to go and what they would like to do. At meal times staff used the jugs of drinks as visual prompts to help people make choices. There were choices about which activity they would like. People were seen interacting with sensory equipment.

People were treated with dignity and respect. We observed that most staff knocked on people's doors and waited for a response before entering. People who chose to be in their bedrooms were checked by staff during the day; at times the checks were task led rather than positive interactions. If a person required support with their personal care then the staff would discretely support them to show respect.

Requires improvement

Is the service responsive?

Our findings

At the last inspection there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because planning and delivery of care was not done in such a way to meet people's individual needs which ensured their safety and welfare. Some people did not appear well cared for. Others were not supported to change their position to minimise their risk of pressure ulceration. One person did not have a care plan and care charts were not fully completed.

The provider sent us an action plan which outlined the actions they would take to improve the service and how they would meet the requirements of the regulations. The action plan stated the provider completed monthly care plan audits; personal care audits were to be carried out and random audits to be carried out by the nurse in charge on the care charts such as repositioning charts. There had been some improvement as people's pressure care was no longer a concern. Appropriate equipment had been used, including air cushions on chairs and air mattresses on beds to minimise the risks of damage to people's skin. There were effective body maps in place to record any noticeable marks on the skin to enable any concerns to be monitored and appropriate treatment to be sought.

People had not received care in line with their plans of care which placed them at risk of receiving care that did not meet their needs. Two staff said they had never looked at care plans whilst working at the home. Another staff member was asked how often they looked at the care plans and they replied "Not often". One person's care plan said "Staff should approach from the left side or front (of the person)". We observed three members of staff, including the registered manager, position themselves on the right hand side to interact, including one assisting them with eating. This person's care plan stated that they preferred to sit in their bedroom to eat their meal because they do not like noise. However, this person was in the dining room having their meal. We spoke to the member of staff helping them to eat and another member of staff close by; neither had knowledge of this person's preferences. This person was observed at lunchtime on both days of the inspection. During both meals this person became aggressive and refused their pureed food. As a result they did not manage to have their main meal. On both days their meal was saved until later and they were also offered a sandwich, which they accepted on the second day.

Another care plan stated staff should support one person in pairs; we saw on three separate occasions a lone member of staff was assisting this person in the bedroom. A third care plan for a person with a specific health need stated "Staff to encourage [name of person] to have a walk every two hours; staff to ensure that the environment is free from clutter and staff to encourage [name of person] to step up one step to practice stairs at home as required by the physiotherapist." Throughout the inspection, the person was not seen standing or walking in line with the guidance in their care plan. They were asked how often they were assisted to walk by care staff and they replied "Every other day". Daily records contained no evidence of the person being offered regular walks or participating in any activities. Therefore, planning and delivery of care was not always done in a way to meet people's individual needs. This put their health and safety at risk because one person was missing meals and another person was not receiving the care they required to meet their healthcare needs .

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection there was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems to enable people to give their views were limited and action plans did not show how concerns raised had been addressed. The complaint procedure had not been updated and it was not in a format that was suitable for all people to understand.

Improvements had been made since our last inspection. Throughout the home there were easy-read picture notices giving clear instructions on how to make a complaint. People said they were aware of how to make a complaint. One resident said "If I had something to say I would just tell them." There was a complaint log in place and no complaints had been received since the last inspection.

People were supported to take part in activities of their choosing. Since our last inspection an activities coordinator has been appointed. The activities coordinator made sure that there was soft background music being

Requires improvement

Is the service responsive?

played. Sensory objects such as dolls and balls were given to each person. In the reception area there was an easy read weekly programme of activities. Activities listed included gardening, flower arranging, music therapy, ball games and poetry. Every person was doing a different activity and the activity coordinator said "I prefer to let the resident choose what they would like to do at any particular time. There is a weekly programme of activities and it is adapted to how people are feeling on the day." This included outings and trips were organised using minibuses or taxis. The activity records were taken home every night by the activity coordinator. This meant that other staff were unable to access them and the registered manager was unable to audit the plans.

One visitor commented that the activities coordinator had made a tremendous difference to the home and to their loved ones well-being. Another visitor said "(The home) was better since they had an activities coordinator in post." We observed positive interactions between the activity coordinator and the people; they ensured that each person was engaged with interests of their choosing.

Inadequate

Is the service well-led?

Our findings

At the last inspection the provider was in breach Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Auditing systems were in place to assess the quality of the service but potential risks to people's health, welfare and safety had not been identified.

The action plan the provider sent us showed they had put monthly environmental audits in place. At this inspection we saw these were not being completed every month despite the overview stating they had been completed in February, March, April, May and June 2015. Following the inspection we were told that a walk around of the environment had been completed in June 2015 but not documented. People walked through the corridors during the inspection grabbing onto rails, walls and other objects in the corridors to steady themselves and could be used by people to assist their mobility. The environmental audit or walkthrough had not identified the continuing risks to people because the hoists and wheelchairs were left without being properly secured. This is despite risk assessments identifying that all hoists and wheelchairs should be stored with brakes left on. At the time of the inspection there was some renovation work being completed on the rooms upstairs. There were people who lived directly next door to this work. There were no barriers in place to prevent people accessing these rooms and there was a risk as tools were left unattended. We spoke to the registered manager who said they had not completed a risk assessment for this work as they had not identified it as a risk to the people. Whilst we were there the risk assessment was completed.

We spoke to the registered manager about their audits who said "I never get time to do my observations properly. The phone rings or I get distracted." Following the inspection the registered manager clarified they were talking about observational audits. Observational audits are specialist qualitative audits designed to help a provider assess the wellbeing of people who live in the home and assess their interactions with staff. We looked at other audits that the registered manager had put in place since the last inspection. The overview stated repositioning chart audits should have been completed but they had not.

Following the inspection the provider said that the repositioning audits were part of the monthly care plan audits. The monthly care plan audit had not been completed for June 2015. The safe catering audit stated it would be completed every fortnight, but the registered manager disagreed with this and felt it should be done monthly. The food and fluid audits had not been completed in June 2015. This meant the manager did not have a clear understanding about why effective audits were important to keep people safe.

Some staff had not received correct training in dementia. However, the registered manager who completed the training audits said "Staff had adequate training. People understand their roles." This comment was not supported when we spoke with care staff as they did not understand how to deliver dementia care and some interactions were not appropriate. For example, we saw some people being spoken to in a child-like manner by members of staff and another member of staff being disrespectful. We asked if there was an action plan to address these shortfalls. We were told by the registered manager there was not one in place. This meant when shortfalls were identified there were no systems to plan and implement improvements.

We spoke to the registered manager about the support they received from the provider. They explained they felt supported and they met regularly. We did not speak with the provider at the inspection but we asked the manager about quality assurance systems in place. Following the inspection the provider told us they have monthly audit meetings. They showed us evidence of only two audit meetings one in February 2015 and one in May 2015. This meant that even though the provider is supportive they have some systems in place to identify shortfalls and implement improvements. However, they had not identified shortfalls that had been identified in the inspection.

At the last inspection care records were being stored in an area which was accessible to unauthorised visitors who could view the personal details of people which breached their confidentiality. This risk had not been reduced as they were still stored in the same unsecure area of the home. The registered manager did not have an explanation as to why they were still being stored in the same place.

Staff were unaware of information contained in the care plans and the registered manager did not have processes in place to monitor this. The registered manager explained

Inadequate

Is the service well-led?

they had tried a range of different checks on the care plans and now it was only random checks. There were no systems in place to ensure that staff were familiar with the care plans. As a result, people were at risk of not having their health needs managed appropriately and receiving care that did not meet their needs. The registered manager did not feel it was important for staff to understand the terminology least restrictive in the mental capacity act. But felt they should have an understanding on a functional level. There was evidence that this had an impact on people's human rights because people were not always given choice about their care. For example, people had not received personal care of their choice due to the lack of capacity assessments and best interest records.

The audits in place had not allowed the registered manager to assess, monitor and improve the quality and safety of the services provided in the home. Neither did they help the registered manager to mitigate the risks relating to the health, safety and welfare of the people with specific health conditions.

The home had a structure of a registered manager supported by a clinical lead nurse. The clinical lead supervised the other nurses. People were clear of the staff structure in the home. During the inspection the registered manager explained the clinical lead had needed some additional time away from the home. However, there was no clear system in place for ensuring the clinical practice was effective. Following the inspection, the provider shared their business continuity plan that confirms a senior nurse will take on this role.

Some supervisions of staff had not been completed. This meant staff had not received regular support or given the opportunity to discuss their development needs.

As a result of this there is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the registered manager was actively participating in the care of the people. They explained that there is an open door policy in the home. Staff said "They (the registered manager) are very social with everybody and very open" and "(The registered manager) is always easy to talk to." A visitor said "The registered manager is approachable and available when needed."

A registered manager has a responsibility to ensure notifications are sent to CQC when a serious incident occurs at the home. There was one occasion when there had been a delay of over a fortnight before CQC were informed. The registered manager stated there was no good reason for the delay. They showed us an accident form analysis. We saw there was one incident which had been referred to the safeguarding team at the local authority, but no notification had been sent to CQC. These inconsistencies meant that CQC were not informed about incidents where people were potentially at risk. At the inspection the registered manager was reminded of the requirement to inform CQC of all serious incidents. They assured us that in future there will not be a delay in notifying us.

The home had a clear culture and ethos based around the Butterfly Project that was promoted by the registered manager. They had regular visits by a representative from Dementia Care Matters to audit the progress that the home was making in relation to this project. All the staff were aware of this ethos and how it was meant to be embedded within their practice. The registered manager did say that they were putting actions from this review into practice.