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Birch Holt Retirement Home

Inspection report

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Date of inspection visit:
10 October 2016
12 October 2016

Date of publication:
12 January 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection. Birch Holt provides accommodation, care and support for up to 26 people. On the day of our inspection 20 older people were living at the home. The service provided care and support to people living with dementia, risk of falls and long term healthcare needs such as diabetes.

We carried out an announced comprehensive inspection at Birch Holt Retirement Home on the 3 and 5 November 2015. Breaches of Regulation were found and the service was placed in special measures. As a result we undertook an inspection on 10 and 12 October 2016 to follow up on whether the required actions had been taken to address the previous breaches identified. Although we found some improvements in areas where we had previously identified concerns at this inspection we found significant risks still remained.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission 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 and associated Regulations about how the service is run. However at the time of our inspection the registered manager was absent from work and the provider's deputy manager had the day to day responsibility for the service.

There were not always sufficient numbers of staff on duty to keep people safe and support their individual needs.

The provider had not protected people's safety by ensuring effective management of medicines. There were multiple concerns related to the administration of people's medicines, for example appropriate guidance was not always available for staff when supporting people with their 'as required' PRN medicines.

Risks related to people's safety had not always been mitigated effectively. For example with regards to accidents and incidents and the setting of specialist care equipment.

The provider had not taken adequate steps to ensure the service was appropriated cleaned. Areas of the service were seen to be grubby and required cleaning.

The provider had not undertaken all appropriate checks on staff to ensure their suitability for employment or specific tasks such as driving people to appointments.

The provider had not taken steps to ensure they were fulling their legal responsibilities in regard to the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

The provider had not sought timely health care intervention for a person whose body weight had fallen.

The systems the provider used to identify staff training requirements had not been effective in ensuring all staff had received the training in a timely manner. Staff supervision minutes provided limited feedback that was designed to develop staff's performance and capability.

The design of some areas within the service were not suitable for their use, for example narrow corridors which were used to move mechanical lifting equipment.

There were several examples within the service of culture, staff approach and physical environment which did not consistently promote people's privacy or dignity.

The provider had not made adequate provision to ensure people's social needs were met. People told us the routines of staff were task orientated and fixed to predefined times.

The provider had made limited improvements to their quality assurance systems since our last inspection. This meant that they did not have clear oversight of the service and the areas which required improvements.

People told us staff were kind and we observed positive interactions between people and staff.

We observed various meals, people told us they enjoyed the food and looked forward to coming to the dining room to spend time with others.

The overall rating for this provider is 'Inadequate'. At the last comprehensive inspection this provider was placed into special measures by CQC. At this inspection there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after all legal requirements have been fulfilled.

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.

We found areas of the home were not clean and systems were not in place to ensure this was undertaken regularly.

Medicines were not consistently managed safely.

Risks related to some peoples care had not been adequately managed and recorded.

The provider had not undertaken all appropriate checks on staff to ensure they were suitable to work within a care setting.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not ensured they were fulling their legal responsibilities in regard to the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

The provider had failed to consistently seek appropriate health care intervention for people.

The provider systems did not clearly identify which staff required training. Staff supervision minutes provided limited feedback that was designed to develop staff's performance and capability.

Is the service caring?

Requires Improvement

The service was not always seen to be caring.

Although we saw positive interaction between people and staff we found people's choice and dignity was not consistently promoted.

Relatives and friends told us they were unrestricted as to when they able to visit people

Peoples care records were held securely.

Is the service responsive?

Inadequate

The service was not always responsive.

We found the provider had not made adequate provision to ensure people's social needs were met.

Aspects of care and routines were seen to be task orientated.

Care plans did not consistently capture people's support needs and health history.

A complaints policy was in place.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to establish quality assurance systems which were used to drive improvement. Accidents were recorded however were not used to analyse trends and influence future staff learning.

The provider had failed to take timely corrective action to the areas of concerns which had been previously identified.

The provider did not have systems to collect and act on feedback from people, their relatives or stakeholders.

Birch Holt Retirement Home

Detailed findings

Background to this inspection

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

We inspected the service on the 10 and 12 October 2016. This was an unannounced inspection. The inspection team consisted of two inspectors. At the time of our inspection the provider had submitted an application to the CQC to alter their registration status from a partnership to a single provider.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for. We looked at care documentation and examined records which related to the running of the service. We looked at six care plans and four staff files, all staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed. We also 'pathway tracked' people living at Birch Holt. This is when we look at care documentation in depth and obtain views on how people found living there. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were unable to talk to us.

We looked at areas of the home including people's bedrooms, bathrooms, lounges and dining area. During our inspection we spoke with 12 people who live at Birch Holt, four visitors, six staff, two visiting health professionals, the provider and the deputy manager.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and members of the public. We spoke with a representative from the Local Authority's contracts and monitoring team. We reviewed notifications of

incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Inadequate

Is the service safe?

Our findings

At the last inspection in November 2015, the provider was in breach of Regulation 12 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured people's safety in relation to security, equipment use, medication and cleanliness. The provider sent us an action plan stating how they would meet the requirements of the regulations by January 2016.

At this inspection we found some improvements in areas where we had previously identified concerns however others had not improved and new areas of concern had also emerged. The provider remained in breach of Regulation 12 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection there were three care staff working from 8am until 2pm followed by two care staff working from 2pm until 10pm when two night staff came on duty. The deputy manager and rotas confirmed this had been the normal routine for several weeks. At times during our inspection there were insufficient numbers of staff on duty to keep people safe and support their individual needs. Four of the 19 people living at the service, required two staff to support them each time they wished to move using mechanical lifting equipment. This meant that during the afternoon two carers were tasked with preparing peoples' afternoon meal, undertake medicine duties and answer call bells. One staff member said, "It doesn't work well, too much to do and if someone needs moving in their room there isn't anyone around in the rest of the home." All staff we spoke to told us they felt there were not enough staff on shifts to support people. Inspectors identified various issues throughout the inspection. For example, we heard one person calling out to staff for assistance. This person was being cared for in their bed, their lunch tray remained in front of them at 3.30pm; staff had not ensured their call bell was within reach so they could not call for help if the needed it. This placed the person at risk of harm. During our inspection we saw that people were left unattended for extended periods in lounges and their rooms whilst staff attended to other routine tasks. One person's relative said, "The staff can be so busy they don't always have the chance to keep an eye on residents as well as they should."

The issues related to insufficient numbers of staff are a breach in Regulation 18 HSCA (RA) Regulations 2014.

At our last inspection in November 2015, we found people who had been assessed as at risk of possible skin damage and who used specialist airflow mattresses did not consistently have this equipment set correctly. These mattresses are designed to provide relief to skin pressure areas. It is important this equipment is set correctly and in line with a person's weight and manufacturer's instructions. At this inspection we found three people did not have their mattresses set correctly. This placed these people at greater risk of skin pressure damage. The deputy manager showed documentary evidence that they checked these themselves on a regular basis however when they were not on shift this task was not delegated to another staff member.

At our last inspection we found concerns with the storage and administration of medicines. At this inspection although it was apparent a new medicine system had been established since our last inspection

there continued to be concerns. For example we found one person who was being cared for in their bed had a tablet on the floor in their room. We checked this person's recent medicines administration records (MAR) and all medicines had been signed as taken. Staff were unable to identify whose medicine this was. This meant the provider could not be assured this person had been supported appropriately with their medicines. This same person had been prescribed PRN 'as required' paracetamol for pain relief by their GP however their MAR was incorrect and stated a different pain relieving medicine had been signed for by staff. This meant there was a greater risk this person could being given the incorrect medicine. Another person had a prescribed tablet in their room in a small container however a staff member had signed their MAR to state they had taken it. The provider had not ensured staff had clear guidance to follow whilst supporting people who had been prescribed PRN medicines. For example, PRN medicines are prescribed to be given 'as required' however one person's MAR identified they had taken it twice a day for an extended period. Staff had not raised that this medicine was no longer being taken 'as required' to the person's GP. Other people had one to two tablets 'as required' on their MAR however staff had no guidance to follow as to when to offer the variable dose.

Risks related to accidents and incidents were not effectively managed. One person had fallen from their bed on five occasions in eight months. There was no evidence of a falls risk assessment being undertaken or any guidance for staff within their care plan which indicated this was a risk. The registered manager had completed an audit which had identified this person had fallen out of bed on multiple occasions. However the recorded suggested action on the audit of 'placing a crash mat' at the side of the person's bed was not evident in their care plan. The deputy manager located, in the empty room next door, a crash mat which they believed was being used during the night; however could not confirm if night staff were using this. Additionally the person's bed was not against a wall so two crash mats would have been required to ensure this was an effective control measure. Another person had recently fallen in their room and the accident and incident form provided an overview of the incident however from listening to the person describe the incident it became apparent staff had failed to accurately capture the sequence of events. Accurate recording of accidents and incidents is important; for example should this information be required by a health care professional at a later date. We found additional risks had not been appropriately assessed. For example two people who shared a room had one call bell however both were unable to walk. Another person who had a visual impairment had been provided with two cans of ant killer for their room by the provider.

The issues above issues related to people's safety are a breach in Regulation 12 HSCA (RA) Regulations 2014.

At our last inspection in November 2015 we found areas of the home were not clean. At this inspection we found some renovation improvement works had taken place which had eliminated a previous strong unpleasant odour in the home. However we found areas of the service remained grubby. The service employed one domestic cleaner who worked four days a week between 8am and 1pm. Outside of these hours the responsibility fell to care staff whom we identified were under pressure with their caring duties. This meant the provider had no arrangements for cleaning three days a week. The deputy manager told us the domestic cleaner concentrated on communal areas and toilets but did not have sufficient time to undertake more robust deep cleaning in people's rooms. We found carpets within people's rooms were in need of vacuuming and under some people's bed there was a significant accumulation of dust. Most people's rooms did not have bin liners in them, yet staff were depositing their gloves in them after supporting people with personal care. A room where two people shared had an unpleasant odour; a commode which required emptying had not been cleaned by 11.30am. Both people had been supported to a lounge prior to 9am so staff had the opportunity to access the room and clean it.

These issues identified with the cleanliness of the service were a breach in Regulation 15 HSCA (RA) Regulations 2014.

At our last inspection we found a member of staff did not have a Disclosure and Barring Service (DBS) check completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. At this inspection we found all staff had a DBS check. However we found a staff member who did not have any employment references. Additionally for those staff whose DBS returns indicated there had been prior convictions the provider could not evidence what steps they had taken to assure themselves these staff were suitable to work within a care setting. It is good practice to record either within interview or supervision records that these matters had been discussed with the employee to assure the provider they are suitable to work within care.

We identified that staff supported people to appointments with external health care professionals in their own vehicles. However the provider had not made appropriate checks on these staff's documentation such as driving licence and insurance. This meant the provider could not be assured these staff were safe to drive people.

The identified shortfalls related to staff employment are a breach in Regulation 19 HSCA (RA) Regulations 2014.

At our last inspection we identified risks in relation to the security of the service in regard to the front door. The provider had taken appropriate steps to mitigate these. Other environmental risks such as those related to fire were also now being managed safely. The provider had commissioned an external fire assessment and had taken steps to action the identified actions from this. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Maintenance and servicing of equipment such as fire alarm, portable appliance testing (PAT) and boiler were seen to have been undertaken. Staff were clear on how to raise issues regarding maintenance. One member of staff told us, "They are here most days so it's straight forward to get things sorted."

Care staff were able to identify their responsibilities to keep people safe from harm or abuse. They had an understanding of the different types of abuse. Care staff told us they had confidence senior staff would take action if they raised concerns relating to potential abuse. One member of staff told us, "The deputy would take charge and get things sorted correctly." Care staff told us if they were not satisfied with the response from senior staff they would defer concerns to the local authority or the CQC.

Requires Improvement

Is the service effective?

Our findings

The provider had not taken steps which ensured they had clear oversight of their legal responsibilities in regard to the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Care documentation contained limited information or reference to people's mental capacity. There were people living at the service who were living with dementia type illness. Staff told us some people lacked the capacity to make some of their daily living decisions, however there was no evidence how best interest decisions had been reached for these; for example in regard to medicines. The deputy manager told us as a result of recently attending a training course on DoLS they intended to submit applications to the local DoLS authorising body for four people living at the service. However these people's care documentation did not demonstrate mental capacity assessments had been undertaken. These assessments would assist in establishing what decisions people lack capacity for and how their liberties were being restricted by their daily care routines. Two of these people shared a room and although their care documentation contained a signed letter by staff and relatives there was no evidence of the involvement of health or social care professionals in this decision making process. These two people's care documentation did not make it clear whether their relatives had the authority to advocate for them for this decision.

The identified shortfalls related to the providers understanding of consent are a breach in Regulation 11 HSCA (RA) Regulations 2014.

Although people told us that they were supported to maintain their health we found examples where staff had not been proactive. A health care professional who visited the service regularly told us, "If you are mobile and have capacity the care seems alright but for those with higher needs it can be harder for the staff to pick up where support is required."

Regular monitoring of people's body weight is a tool used to highlight potential adverse health concerns. People were being weighed regularly and staff recorded this. However staff had taken no actions in response to one person's weight loss. This person had lost 13 kilograms in a nine month period and no health care intervention had been sought. We raised this concern with the deputy manager who immediately made contact with this person's GP to request further investigation.

The failure to take seek timely health care intervention is a breach of Regulation 9 HSCA (RA) Regulations 2014.

At our last inspection we identified staff supervision was brief and provided limited feedback that was designed to develop staff performance and capability. At this inspection we found no improvement. The registered manager had no supervision in place, staff were not able to identify when they had their next supervision. The deputy manager told us staff had one appraisal a year and only underwent supervision if a development area was identified or they were a new member of staff on their probation. One staff member's annual appraisal from August 2016 was short and provided limited detail on how the staff members work year had gone. The section identifying 'training needs' was blank even though the training matrix identified this staff member required refreshers in several training courses. The main summary stated, 'works well and

covers shifts'. Staff supervision and appraisal failed to evidence how senior staff encouraged staff to reflect on learning from practice, offer personal support and identify professional development opportunities. Although staff told us they generally felt supported by senior staff we found this was not consistently apparent by the providers actions. For example staff told us they had identified to senior staff that they felt there were insufficient numbers of staff to effectively support people at certain times and there had been no immediate actions taken such as the use of agency staff.

At our last inspection we found information related to staff training was not easily accessible. The document used to collate staff training was inaccurate and it was necessary to go through staff's individual files to find training certificates. Having access to this information could be useful for senior staff when planning rotas so skills sets could be best matched to support people effectively. At this inspection we found minor improvements had been made however there remained inaccuracies. For example the training overview document stated one staff member last completed their first aid training in 2014 however the most recent certificate in their file was dated 2007. These discrepancies meant the provider could not be assured which staff required updates or refresher training. We identified that most care staff had not received training in MCA; two who had, did so in 2008. Due to updates in legislation there have been significant changes since this date. Although most staff had recently completed infection control training we saw examples of staff demonstrating poor practice for example removing their aprons after they had left a person's room rather than before.

The above concerns relating to staff receiving appropriate support and receiving effective training are a breach in breach in Regulation 18 HSCA (RA) Regulations 2014.

Areas of the home were not suitably designed for their purpose. All people who required mechanical lifting equipment to support them to move were living on the ground floor of the home. Throughout the inspection we noted staff found difficultly in manoeuvring this lifting equipment. The narrow corridor and tight turn prevented easy access and each time equipment was moved it blocked door ways. Staff had to open and close an adjoining door to assist with the movement of the equipment into a lounge. One staff member said, "It is far from ideal, these corridors were not designed for hoists being moved in and out." Another staff member said, "It can slow you down when you are trying to move it about, you can get a bit wedged and need someone else to help." The home had one bath which was fitted with lifting equipment fitted to support people. This was located on the first floor. This meant people whose rooms were on the ground floor would need to be supported to move upstairs via the home's lift if they wished to have a bath. The four people who required mechanical equipment to move all had rooms on the ground floor which meant they would be required to use the lift to access the bath. One staff member said, "If residents who require hoisting wanted to use the bath upstairs it takes a lot of manoeuvres, it's not straight forward." The areas related to the design of the service require improvement.

People mainly spoke positively about mealtimes at the service. The majority of people came to the dining room for their lunch and afternoon meals. One person told us, "I spend most of my day in my room but I go down for meals." One person ate in one of the home's lounges using a tray table and others chose to eat in their rooms. There were drinks and condiments available. People told us there was always a choice on offer and that the cook was flexible at lunch time if a different request was made. One person who was a vegetarian spoke highly of the options they were provided. However one person with a visual impairment told us they struggled to eat off a white plate. They told us they had raised this issue with staff as, "They couldn't see anything on a white plate." We spoke to the deputy manager regarding this issue; they told us they were aware of the concern however no action had yet be taken such as using an alternative colour. They assured us they would take steps to ensure this was undertaken. This is an area that requires improvement.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in November 2015, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured people's dignity was consistently protected. The provider sent us an action plan stating how they would meet the requirements of the regulations by January 2016.

At this inspection we some improvements had been made and the provider was meeting the requirements of Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However despite these improvements, we found some areas related to promoting people's dignity remained and required improvement.

We found examples with staff approach and the home's environment which did not consistently promote people's privacy or dignity. For example a communal toilet on the first floor did not have a lock fitted to enable people to have privacy. During the lunchtime meal service, on the first day of our inspection, a person who was eating their lunch in a lounge from a tray table had their plate moved out of their reach so as a staff member could support them with their medicines. The staff member did not communicate with the person before doing this. When staff updated people's daily care records they did this at tables in the dining room. On the first day of our inspection two staff did this at the same time. However there were people sat in the adjoining lounge who told us they enjoyed it when staff would sit and chat with them. On the second day of our inspection a hairdresser was cutting people's hair in a communal bathroom. This bathroom had a toilet in it and no window. Staff told us there was no other suitable location for this however people could request to have their hair cut in their rooms. On the day of our inspection all people who used the hairdresser service did so in this communal bathroom. One person told us, "I've never thought about it really, we've always had our hair cut in there, I can't remember being asked if I wanted it done anywhere else."

Staff had been working at the service for extended periods and knew people well and were knowledgeable about their daily care and support needs. People and their relatives told us staff were caring and kind. One person said, "The carers hold the place together, always cheery and do their best." A relative said, "They looked rushed off their feet but they are always happy and make me welcome." We observed multiple kind and caring interactions between staff and people. For example staff were seen to comment on a person's hair when they had visited the hairdresser. Another staff member discreetly supported a person whose clothes had become ruffled from sitting. We saw staff knocking on closed doors before entering and spoke to people in a polite and courteous manner. One person told us they enjoyed a 'laugh and a joke' with staff.

People told us the lunch time meal in the dining room was the main sociable event of the day. One person said, "I like to come down for my lunch and have a natter." People sat in friendship groups and enjoying chatting. Music was playing and staff interacted with people in a friendly manner. People were heard joining in with a staff member who was singing. One person reprimanded staff when a door slammed; a staff member ensured they went over to the person to apologise.

People's care documentation was stored securely within the service. Care staff were aware of the importance of protecting people's confidential information. Staff were seen to return care records to the home's office or care records cupboard once they had completed using them.

We saw visitors were welcomed during our visit. Relatives told us they visited at various times of the day and were made welcome by staff. One relative commented, "Generally I am happy with the care I see provided, staff know my mum well and do their best to jolly her along." Another relative said, "I know the deputy will always ring me if there is ever a problem which is reassuring."

Inadequate

Is the service responsive?

Our findings

At the last inspection in November 2015, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured regular meaningful activities had been established which met people's social needs. The provider sent us an action plan stating how they would meet the requirements of the regulations by January 2016.

At this inspection we found there had been no improvements in this area and we also identified new concerns. The provider remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found people's care plans did not provide a person centred picture of their support needs. They lacked detail, personalisation and were not up-to-date. At this inspection we found the provider had implemented a new care planning system which provided clear headings related to multiple aspects of care which senior staff had begun to populate. Staff told us these new care plans were more detailed and were clearer and easier to follow. Despite these improvements we found examples where care plans had not captured information which would be important for staff to be aware of whilst delivering care. For example a health care professional told us about one person's complex medical condition however their care plan made no reference to this. Daily care records were written once a day after lunch; they continued to be generic and not person centred. They provided limited insight into people's moods and specifics of how they had spent their time. For example one person's complete daily care notes for one day stated, "Full personal care, all is good, tea in room, no problems." This lack of person centred detail meant that senior staff would be unable to determine whether correct care was being delivered consistently when auditing these documents.

At our last inspection we found people had limited opportunities to engage in meaningful activities. At this inspection we found the activities available had reduced. The member of care staff who had been previously allocated some time to develop this area had stopped due to the necessity for them to deliver care. People and their relatives continued to tell us they would like to see more going on that people could be involved in. During our inspection the only organised activity which took place that was in line with the providers activities planner was a visit from a hairdresser. People sat for extended periods in both lounges with limited interaction or stimulation other than tea and coffee rounds. A staff member told us, "I would like to spend more time with people especially ones in their rooms but there isn't time." One person told us that they were looking for another home to live in as they were 'bored.' One relative told us, "The odd trip out for an outing would be nice to see." Another relative said, "When we were shown round we were told there was a full itinerary of activities, this just hasn't happened." A person who was being care for in their bed was seen to have picked off sections of their wallpaper dado rail by their bed. Their care plan did not identify this as an expected behaviour and staff could not offer an explanation as to why they were doing this.

Many of the routines of the home were task orientated and lacked person centred consideration. Staff told us that all but two people had their breakfast taken to them before the night staff finished their shift at 8am. These people's care plans did not identify this was their preferred choice. One person told us, "They usually

wake us between 6-7 am as they have to get everything done by 8am when their shift ends." Another person said, "It would be nice to get a lie in now and again." People told us during the day there was one tea and coffee round in the morning and another in the afternoon and they would not usually ask for a hot drink outside these times. One person said, "I wouldn't want to bother the girls." During the afternoon people were being asked what they wanted for the following days lunch however there were people living with memory loss and dementia type illnesses. We asked a staff member why this was being done and they told us they were not sure but it is what 'they have always done'. One person who had not taken their medicines at 8am told staff prior to moving into the service they took their medicines at 10am and preferred to take them at this time. The provider told us it had not been possible to accommodate this as it did not fit in with the home's predefined medicines round times.

The lack of regular meaningful activities, shortfalls in person centred care and involving people was a breach in Regulation 9 HSCA (RA) Regulations 2014.

The home's complaints log showed there had been no recent complaints recorded. We saw historic complaints had been appropriately responded to. We spoke to people about how they would raise concerns if they had any. Most people said they would speak to the staff or the deputy manager. One person said, "I would speak to a carer if I was not happy about something." A visiting relative said they would, "Always speak to the deputy manager if they wanted an update or raise a concern."

Inadequate

Is the service well-led?

Our findings

At the last inspection in November 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to establish effective quality assurance processes. The provider sent us an action plan stating how they would meet the requirements of the regulations by January 2016.

At this inspection we found some improvements in aspects of quality assurance where we had previously identified concerns; however new areas requiring improvement were found during this inspection. The provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had a registered manager in post they were absent from work at the time of our inspection. The provider's deputy manager was in day to day charge of the service.

Our inspection in November 2015 found the provider did not have systems which afforded them clear oversight of the service. At this inspection we found the provider had begun to establish quality assurance processes however these had failed to identify the areas of concern we found. For example audits had failed to identify the shortfalls in cleaning, staff records, medicines and equipment set correctly. The provider had not requested the company providing their medicines to undertake an audit of their medicines. The deputy manager said, "I didn't know this was something they would do."

At our inspection in November 2015 we found care documentation did not provide clear and accurate guidance for staff to follow in regard to meeting people's support needs. At this inspection we found the provider had begun using an electronic system for designing care plans. Staff told us these were easier to follow and contained more detailed information, on a wider range of people's support needs. Of the 19 people living at the service 10 were waiting for their care plans to be updated to the new format. This meant in the 11 months since our previous inspection only nine people had new care plans completed. The provider told us there had been various delays in implementing the new electronic care plans. However at the time of the inspection care staff were unable to continue to transfer care plans to the new format as the registered manager, who had been absent from work since 17 September 2016, had taken the service's computer home with them. The deputy manager told us the registered manager was updating care plans at their home address whilst they were absent from work. This meant the registered manager was updating care plans in isolation and limited their capacity to speak to people or care staff during this re-writing process. This also meant staff were unable to update care plans for people with the new format as they did not have access to a computer. The deputy told us one feature of the new care planning system was that it would 'flag' up electronic reminders however as the computer was not at the service they were unable to receive these electronic prompts. This also meant that the provider could not be assured of the confidentiality of this information being held on computer whilst away from the service.

The provider had not established effective systems to capture feedback from people or stakeholders. The most recent satisfaction survey for people had no date attached to them, were anonymous and allowed for

only ticked responses. There was no summary of actions taken in response to the survey. There had been one 'residents meeting' in 2016 which five people had attended. There was no evidence as to how the provider collected feedback from the majority of people who did not attend this meeting. There was no evidence that the provider sought feedback from people's relatives or external stakeholders such as health and social care professionals who had regular contact with the service.

Staff told us the pressures in care routines created by insufficient staff had been an issue for several months. Staff said they had raised these concerns with the deputy manager who in turn had informed the provider. The provider told us they were actively recruiting for staff; however they had not taken short term steps to alleviate these shortfalls whilst they sought to recruit, such as the use of agency staff for care or cleaning duties.

The above concerns related to governance and oversight of the service are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection the provider had commissioned various external governance checks which had identified some areas which required attention in relation to the physical environment. There was evidence the provider had used these to make improvements and reduced identified risks. External consultants had reviewed areas such as fire and health and safety. One member of staff said, "A fair amount of improvements have been made, but to be honest they needed doing as the building needed some money put into it." Other more routine health and safety checks had also been more robustly completed and recorded since our inspection in relation to fire.

Staff continued to say they felt supported by senior staff. One member of care staff told us, "Not sure what we would do without the deputy manager, they go above and beyond to keep things running." Another said, "If I have a problem I can get the support I need."

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure peoples care was meeting reflecting their preferences. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not taken appropriate steps to ensure people where people lacked capacity were supported in line with the Mental Capacity Act (MCA) 2005. Regulation 9(1)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not protected people against the risks associated with the unsafe use and management of medicines. Regulation 12(2)(g) The registered provider had not ensured people's safety and welfare had been protected by adequately assessing risk and mitigating the risk. Regulation 12(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not taken steps to ensure the premises were clean. Regulation 15(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. Regulation 17(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not established effective recruitment procedures which ensured persons employed were of good character. Regulation 19(1)(a)2

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured there was sufficient numbers of suitably qualified, skilled and experienced staff deployed in order to ensure people's safety and welfare. Regulation 18(1)