Raveedha Care Limited

Symonds House

Inspection report

44 Symonds Lane
Linton
Cambridgeshire
CB21 4HY
Tel: 01223 891237
Website: www.symondshouse.com

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Ratings

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

Overall summary

Symonds House is registered to provide accommodation and care with nursing to up to 58 older people. The home is a converted Victorian property and accommodation is offered on two floors. The service is provided in four units, each of which has lounge, dining, kitchen and bathroom facilities as well as single and double bedrooms.

This inspection took place on 03 March 2015 and was unannounced. There were 41 people in residence.

The last inspection of this service was on 07 August 2014. During this inspection we found that the provider was failing to ensure that people's privacy, dignity and independence were respected and upheld and that staff were failing to put their training into practice in a number of areas. We also found that the provider still did not have an effective system in place to assess and monitor the quality of the service that people received. The provider sent us an action plan and told us that they would be compliant with all the regulations by 30 September 2014.

This service requires a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

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. At the time of the inspection on 03 March 2015 there was no registered manager in place. The previous registered manager had left in October 2014.

Staff were properly recruited and were knowledgeable about their responsibilities to safeguard people from harm. Potential risks to people were identified and managed so that the risks were minimised. People were supported to maintain their health. Medicines were not managed in a way that ensured that people received their medicines safely and as prescribed.

There were not enough staff to make sure that people's needs were met safely and in the way they preferred. Staff had undertaken a range of training relevant to their work, but they did not always put their training into practice. People were not always supported to make informed choices.

Some staff showed that they genuinely cared about the people they were looking after, whilst others showed no compassion and did not always treat people with the kindness and warmth they deserved. Some staff did not have a good enough grasp of the English language to be able to communicate effectively with people.

People's needs relating to food and drink were supported but people's experiences of mealtimes varied depending on which area of the home they lived in. People were not always supported to maintain their independence with eating and drinking. Most staff knew about mental capacity. However, the rights of people who could not make decisions for themselves were not always upheld lawfully as their capacity to make certain decisions had not been assessed.

Care plans showed that people's relatives had been involved in planning the person's care and support. Care plans gave staff detailed guidance on the care each person needed and the ways they preferred their care to be delivered by the staff. People and their relatives said they would raise any concerns with the staff, although the advertised complaints procedure gave people incorrect information.

People, relatives and staff were concerned about the number of managers who had been employed at the home. Staff did not receive regular supervision or appraisals and said they felt unsupported. The provider's system to audit and monitor the service provided was not effective and the provider had failed to notify the Commission of significant events, which they are required to do.

We found a number of breaches of the Health and Social Care Act (Regulated Activities) Regulations 2010, which correspond to the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires Improvement

The service was not always safe

There were not enough staff to make sure that people were safe and that their needs were met at all times.

People did not always receive their medicines safely.

The provider had an effective recruitment procedure in place to ensure that only staff suitable to work in a care environment were employed. Staff were trained and knowledgeable about safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective

Staff did not always put their training into practice to enable people living with dementia to make choices and maintain their independence with their meals.

In some areas of the home people were supported well with their meals, while support in other areas required improvement so that people had a better experience at mealtimes. People were supported to maintain their health.

The rights of people who were not able to make decisions for themselves were not always protected as capacity assessments had not been completed as required by the Mental Capacity Act 2005. There was insufficient evidence that consent to care had been obtained correctly from people deemed as having mental capacity.

Is the service caring?

Inadequate

The service was not caring

People were not always treated with respect for their privacy and dignity and confidential information about people was not kept securely.

Some staff showed no compassion, warmth or empathy towards people and support to meet people's needs was not always provided in a kind and sensitive way.

Other staff showed that they knew people well, had good, friendly relationships with them and cared about the people they were caring for.

Is the service responsive?

Requires Improvement

The service was not always responsive

The activities provided did not offer sufficient meaningful stimulation and entertainment and did not support people's individual hobbies and interests.

Summary of findings

Relatives were involved in planning their family member's care and support. Care plans gave staff detailed information on how to support people and keep them safe and the plans were reviewed and updated regularly.

People and their relatives would raise any concerns with the staff. The poster advertising the provider's complaints policy and procedure did not have the correct information, so people had no information about who else they could complain to if needed.

Is the service well-led?

Inadequate

The service was not well-led

The service had had several managers in a short period of time and people and their relatives did not know who was managing the service.

The provider's system for auditing and monitoring the quality of the service was not effective. No adequate analysis of accidents or incidents had taken place.

The provider had failed to notify the Commission of significant events, which they are required to do by law.

Symonds 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 unannounced inspection was carried out on 03 March 2015 by two inspectors, a specialist advisor and an expert-by-experience. The specialist advisor was a registered nurse who had experience inspecting care services that provide nursing care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience at this inspection had expertise in caring for people living with dementia.

We looked at information we held about the service and used this information as part of our inspection planning. We looked at the notifications that the provider had sent to us. Notifications are information about important events that happen in the home that the provider is required by law to notify us about.

We watched how the staff interacted with people who lived at Symonds House. We used the Short Observational Framework for Inspection (SOFI) in two of the lounges. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 10 people who lived at Symonds House, four relatives and a GP. We spoke with nine members of staff and the interim manager. We looked at nine people's care records as well as other records relating to the management of the home, such as staff meeting minutes and falls analysis information.

Requires Improvement

Is the service safe?

Our findings

People, relatives and staff said there were not enough staff. One person told us, "Since I had a fall they told me I had to be watched all the time, but there are not enough staff. I ring my bell and I have to wait." They added, "If there was a fire I wouldn't know what to do." Another person said, "When I ring my call bell staff often come and say 'sorry we're busy'." A third person told us, "There are not enough staff. They are always running about and if I need something I have to wait. Sometimes it takes a long time." We sat in one unit for 25 minutes before we saw any staff attend to check that people were safe and comfortable.

Relatives said they have often had to help people who needed to go to the toilet because there were no staff available. One said, "People are just left to sit, there are no carers in the lounge." Another relative told us, "I've lost count of the number of times I've come in and have heard people asking to go to the toilet." They added that the care staff have told them people will have to wait because they need two staff to use the hoist and the other member of staff is doing something else. We saw one person getting quite distressed because they needed the toilet. Staff told us the person would have to wait until a second staff member returned from their break. This meant that there were not enough staff to meet people's care needs.

During the inspection we noted that at times there were enough staff on duty, but at other times there were not. During the afternoon, on the unit where people with the most complex needs live, an agency care worker who had not worked at the home before was left alone in the lounge. This agency worker attempted to assist one person to get out of their chair in a way that put the person at serious risk of harm. We spent some considerable time in one area without seeing any staff and we sat with people in their bedrooms in two other areas and did not see any staff checking on people who were not in the lounges. A member of kitchen staff told other staff they had been sent to work in one of the units because of the inspection.

Staff told us that recently an additional member of staff had been employed to help during the morning in the two units upstairs, "which has helped". However, another member of staff said that there had been days recently when there had been only three staff to cover both of the upstairs units, where a number of people needed two staff to assist them. This meant that staff were "rushed off our feet, running backwards and forwards" and people did not get the care they needed at the time they preferred.

Some staff, who did not have English as their first language, did not have the skills to communicate effectively with people. A number of people, their relatives and staff commented on this. One person said, "There is a tremendous language difficulty [with some of the care workers]". This person told us they had "given up" trying to explain what they wanted as some care workers had "difficulty understanding me and I have difficulty understanding some of them." One member of staff said, "The residents have a difficult time understanding the accents of the agency carers. Permanent staff often have to translate for residents." Another member of staff told us, "It's very difficult when there are agency staff as….their accents are difficult to understand." A third said, "It is very hard to communicate with them [agency staff] and make them understand what residents need." This staff member was concerned that some agency staff did not understand people's needs associated with medical conditions, such as diabetes. This meant that the provider had employed staff who were not suitably skilled to effectively support the people who lived at Symonds House.

These matters were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way medicines were managed. Medicines were administered to people by the nurses on duty. People told us that "in general" they were given their medicines on time and they were given pain relief when they needed it. Records showed that medicines were received into the home, stored and disposed of safely and according to good practice guidelines. Medicine administration record (MAR) charts had been signed to show that people had been given their medicines as they were prescribed to be given. Nurses were clear about the side effects associated with some medicines, such as Alendronic acid, and the way in which these should be given. Nurses knew how each person preferred to take their medicines and one nurse

Is the service safe?

described how they encouraged one person who was not keen on taking their medicines. We saw another nurse explain to one person what each medicine was for and wait patiently while the person took their medicines.

However, we found prescribed medicines, which people had not taken, left where other people could reach them. Audits of the amounts of medicine in stock could not be undertaken as amounts of medicines remaining from the previous cycle had not been carried forward. We saw one nurse sign the MAR chart before she had given the person their medicine, not afterwards, which is a requirement of record keeping. This meant that people had not always received their medicines safely.

These matters were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12(1) and (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the people we spoke with said, "I feel safe, no-one would hurt me." We asked people's relatives if they thought their family members were safe at Symonds House. One relative told us, "My [family member] is in safe hands." However, another relative said their family member was only safe because they "can't move without help" and a third relative told us, "My [family member] is safe only inasmuch as s/he has 24/7 care and they would call the GP if s/he is not well."

Staff told us they had undertaken training in safeguarding adults and they demonstrated an understanding of safeguarding. They showed that they would recognise abuse and said they would report to the senior staff on duty. Staff said they would be able to find a telephone number to ring an external agency if they had concerns. There were no posters about abuse on display, which meant that there was no information for people using the service, their relatives or visitors to refer to if they had any concerns.

There were systems in place to reduce the risk of people being harmed. Care records for people who lived at the home showed that any potential risks to people had been assessed. These included risks associated with nutrition and hydration, falls, pressure areas and mobility. Plans had been put in place so that there was guidance for staff on how to minimise the risks. Staff described how they would reduce risks, for example by regularly turning people who were at risk of getting pressure sores and using pressure-relieving equipment. One staff member told us that instructions for staff relating to the care of one person at night had been amended to reflect the person's changed needs and this had ensured that the person was safe.

A range of equipment such as hoists and pressure-relieving mattresses was in use for people who needed it. However, we found that some equipment was not used appropriately. We found a number of people in their rooms who had no means of getting help, other than by shouting out, as they could not reach, or could not use their call bells. Another person told us that a member of staff had given them a 'new' armchair but they did not feel safe sitting in it. At our intervention staff provided the person with another chair and the person felt much safer. These were examples of when people had been put at risk of harm.

Staff told us that they had undergone a thorough recruitment process before they were employed. They told us that as part of the process they had completed an application form and had an interview. The provider had checked their criminal record and taken up two references before they were allowed to start work at the home. This meant that the provider had taken the required steps to make sure that staff were suitable to work with people living at the care home.

Requires Improvement

Is the service effective?

Our findings

Following our inspection in August 2014 we issued the provider with a compliance action because trained staff had failed to apply their training into practice, which meant that people's mental and physical health needs were not always safely or appropriately met. The provider had sent us an action plan, which detailed the actions they were going to take so that they would be compliant with the regulations. They said that staff meetings would be used as training sessions for staff and that staff supervisions would be used to make sure that staff put their training into practice. They stated they would be compliant by 30 September 2014.

During this inspection we found that staff did not put the training that they had received in respect of caring for people living with dementia into practice. For example, people were asked verbally what they would like to eat or drink. They were not shown the actual choices, such as glasses of orange juice or water and no pictures were used to help people make an informed choice about their meals. When we asked one member of staff how this would work for someone with dementia they were unable to tell us.

The provider had told us they would use staff supervision sessions to check that staff were putting their training into practice. However, staff told us that they had not had supervision sessions 'for a long time'. The interim manager did not provide us with evidence that staff supervision had been carried out.

Staff told us they had had an induction when they first started working at the home. One member of staff said that their induction training consisted of three days, two of which were spent sitting in a room with another new member of staff watching DVDs on a range of training topics. They said that they felt there had been no checks made on what they had actually learnt. They had undergone further training since, in a range of topics relevant to their work. Following the inspection the interim manager sent us a record of the training staff had undertaken. This showed that most staff were up to date with most of the training. Further training in the majority of topics also meant that staff sat and watched a DVD. The interim manager was not able to show us that any assessments of staff's competence to carry out their role effectively had been undertaken, or describe how the effectiveness of staffs' training was monitored. This meant that there was no process in place to make sure that staff had the necessary skills and knowledge to do their job well.

These matters were a continued breach of Regulation 23(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and found that some staff understood the meaning of mental capacity. They knew that many of the people living at Symonds House lacked capacity to make informed decisions.

However, one of the senior staff showed that their knowledge and understanding of MCA and DoLS was very limited. They said that, "There has never been a DoLS here" and went on to say "we don't need to do this." They had not recognised the legal obligations of the service to protect the rights of people who could not make decisions for themselves. They said, "Most people here don't have capacity. We work closely with relatives to ensure they are making decisions in the person's best interests." When we looked at care records we found that assessments of some people's capacity had not been completed. This meant that the rights of people who lacked capacity to make certain decisions for themselves were not being upheld.

The interim manager told us that a Do Not Attempt Resuscitation (DNAR) form had been completed for every person who lived at Symonds House. In the care records we looked at we found that a number of DNAR forms had been signed by people's relatives. In two instances, it was recorded that people were 'mentally alert' and 'have capacity' but the DNAR form had been signed by a relative. On one of the forms the GP had written 'not appropriate to discuss with patient'. We saw nothing further recorded in the care records to explain why the person had not been involved in the decision. The interim manager was not able to explain this. This meant that clear procedures to get valid consent were not being followed in practice.

Requires Improvement

Is the service effective?

These matters were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us that they liked living at Symonds House. One person said "It's quite nice living here." One of the relatives we spoke with was happy with the care their family member received and told us, "If I end up here in my old age, that's fine by me."

People and their relatives had mixed views about the food. One person said their meal was "very very nice", another said the food was "good" and a relative commented that "the food always looks good and smells nice." However, other people were less positive. One person told us, "The food is dreadful." We found that the meals did not look appetizing. One choice was very dry. The second choice looked bland and uninteresting.

Staff told us that there was a choice of two main meals at lunchtime and that people had been asked the previous day which meal they would like. Although most people received the main course they had ordered, people were not offered a choice of vegetables, even though different vegetables were available. In one unit the last person to be served was not given the meal they had ordered as there was none left. They did not like the alternative. A member of the kitchen staff came to ask them what they would like for their meal but by that time they were quite distressed as everyone else was eating. People who needed soft or pureed food were not given a choice.

Some staff supported people well with their meal. For example, we saw a member of staff sitting with one person, assisting them at the person's own pace, chatting to them and making the meal an enjoyable occasion. Some other staff did not support people well. We saw staff standing over people to assist them with their food. The only conversation one member of staff had with the person they were supporting was "open your mouth please" with each mouthful. One member of staff left the person they were assisting to answer the telephone, without giving the person any explanation.

We found that people had different mealtime experiences depending on which unit they were in. In one unit there were serviettes, condiments and sauces on the tables. People were offered a choice of drinks and were encouraged to have a second helping of food. Care staff discussed with each person whether they wanted to wear protective clothing, what and how much they wanted on their plate and if they wanted gravy. However, in another unit there was little discussion with people about their meal and there were no condiments or drinks on the table. In a third unit people who had their meal in their bedroom were not offered any condiments or sauces with their meal and those in the dining room were just given their plate of food without being told what it was. This meant that people were not always supported well with their meal.

Staff told us, and records confirmed, that an assessment of each person's nutritional and hydration needs was carried out and people's weight was monitored regularly. The assessments had been reviewed and people were referred to a dietician if there were concerns about their weight. People received a special diet when required.

People's healthcare needs were met by a range of healthcare professionals who visited the home. People and their relatives all told us that the staff were good at calling the person's GP when needed. We spoke with a GP who told us they were impressed with the professionalism shown by the nursing staff. Records showed that people had access to a range of other healthcare professionals, such as opticians, dentists and hearing specialists when required. This meant that people were supported to maintain their health.

Inadequate

Is the service caring?

Our findings

People and their relatives had very mixed views about the staff. One person said, "They're very kind" and another told us, "Most of the staff are kind and do their best." One relative said they found the care workers were "good and helpful." Another relative told us that they found the staff "excellent" and that they were "pleased and grateful for the way they look after my [family member]."

However, some people and their relatives were less positive. One relative said, "Some carers don't even try to speak to [my family member]. They just grab him/her. I think [my family member] is frightened the whole time because s/he doesn't know what they are going to do next". This relative told us their family member is "very unhappy now…. very frightened and confused and I think a lot of them are like it." Another relative told us, "I wouldn't like to come here myself. People come in happy and chatty and within six months all they are doing is sleeping in their chairs." One person told us, "I have to go to bed when they [the staff] say. They just go [say] "bed" and I can't say no." This person also said that some care workers "just lug me out of bed. They don't ask if I'm ready." A relative confirmed that their family member is not given a choice of when they get up or go to bed, and that the person is put to bed by 4.30pm. This meant that care workers did not respect people's choices.

We found that although there had been some improvements in the language used to communicate with people since our previous inspection, people's independence with their eating and drinking was still not being maintained. Some staff encouraged people to do as much as they could for themselves. However, we saw a number of instances where staff failed to encourage people to be independent or failed to provide a suitable environment. One person was not encouraged to hold their own cup even though we had already seen that they could do so. One person was encouraged to hold their own spoon but no plate guard was attached to the plate so their food fell from the plate to the floor. In one person's care plan we read that they required specially adapted cutlery: they were not given this and they struggled to eat with the cutlery provided by staff. Several people were left sitting in armchairs with an over-chair table which was either too high or too far away for them to be able to eat comfortably. In particular we saw that people found it difficult to cut up their own food when the table was too high.

A number of staff, although polite and professional in their approach, showed little warmth or compassion towards the people they were looking after. We saw one staff member just walk away from a person who was trying to engage with them, without talking. Another was sitting reading a book and ignoring a person who was struggling to stand up from their chair. A third member of staff put people's lunch down in front of them, saying "here you are" with no explanation of what was on the plate or any other communication. One relative summed it up by saying, "There is no rapport, no bedside manner, no closeness."

During the time we spent on one of the units, a person in their room was constantly calling out, "Somebody help me please." We spent some time with this person whose calls for help decreased and they became calmer while we were with them. We did not see staff enter this person's room or spend time with them, other than at lunch time when a member of staff assisted the person with their meal.

We saw and heard about a number of occasions when people's privacy and dignity were not respected by the staff. Although one person told us staff knocked on their door before entering the room, we saw several staff just walk into people's rooms, even when the person was there. Whilst we were talking to one person in their bedroom a member of the housekeeping staff pushed their cleaning trolley into the room and walked in to start cleaning, without knocking or saying a word. One person told us, "Some carers are better than others. Some will ask permission and give explanations, some won't; it depends on who you get." A relative said, "I don't think they treat people with dignity. People shouldn't have to wait to go to the toilet." In one of the communal lounges one member of staff asked another member of staff a very personal question about one person, loud enough for people sitting there to hear.

These matters were a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

In two of the units we found that people's care records were kept in unlocked cupboards in the lounges. In one unit, the cupboard was full so one person's records were left on the top of the cupboard. In a third unit we saw people's care records were left on a table in the lounge. A member of staff reminded another member of staff that the cupboard should be kept locked. When we checked later in the day the cupboard was still unlocked. People and visitors were able to walk around the units and could have accessed anyone's personal records. This meant that people's confidentiality was not maintained or respected.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that a few of the staff were friendly and attentive and had good, caring relationships with people. On one unit there were two staff who we saw treated people well, showed they cared about people and demonstrated that they wanted to do a good job. They told us how important they felt it was to gain people's trust, which they did by getting to know people well and getting to know how to support them in the way they preferred. One described how they supported one person when they got agitated by spending time with them, talking calmly to them and taking them outside for a walk. The other care worker told us the importance of getting to know each person well so that "you could always know if something was wrong."

The interim manager did not know about local advocacy services or whether any advocates were involved with any of the people who lived at Symonds House. We did not see any information advertised that would have given people or their visitors information about advocacy.

Requires Improvement

Is the service responsive?

Our findings

One relative told us their family member always looked clean and well-groomed. However, another relative said that staff did not dress their family member in the way s/he would have liked: "If s/he knew what s/he looked like s/he'd be really upset." A relative told us that when they took their family member round the corridors in a wheelchair, staff on all the units "seem to know him/her, are very friendly and greet him/her by name." Other people said that they did not think staff knew them well or what might be important to them. One person said, "They don't have the time to sit down and talk to me and get to know me."

Care plans provided staff with detailed guidance about the care and support that each person wanted and the ways they preferred their care and support to be delivered. In one person's care plan, for example, staff were given detailed instructions on how to encourage the person to maintain their independence with their personal care. One relative told us they had seen their family member's care plan and had signed to say that the care described was suitable to meet their family member's needs. In another care plan we saw that the person's relative had signed the plan. They had added 'Thank you!!' with a 'smiley face' symbol to show how pleased they were with the plan of care to be provided. We saw that care plans were reviewed regularly in a very full and positive way. Changes had been made to people's care plans when the person's needs had changed.

We looked at what was provided for people to keep their minds stimulated and to keep them active. We found that people had different experiences depending on which unit they lived in. In one unit, we saw that care workers engaged individuals in an activity they enjoyed or just sat and chatted to them. Some people and their relatives told us that sometimes there were activities in the lounges and there was a religious service once a week, but they said that mostly the staff just left the television on. In one lounge there was a board on the wall with the week's activities. On the board, for Tuesday, 'sing-a-long' and 'exercises' were advertised. During the morning a care worker carried out a quiz involving song lyrics. People were quite engaged and enjoyed the activity. The same activity was then repeated in the afternoon, with the same people, which meant that the range of activities on offer that day was very limited and did not follow the advertised plan.

Most people who were in their bedrooms told us that they were bored and that staff were too busy to spend any time with them. One person said, "There is nothing to do and no-one comes to chat." Another told us, "They don't come in and talk, they are too busy." This person added, "I hate it, the future feels bleak." A third person said, "I don't do very much, I mainly sit in my room and watch television. I feel very isolated." During the inspection we saw almost no engagement by staff with people who were in their rooms, other than when they provided care.

Several people told us they really enjoyed going to the day centre, which operated at Symonds House for the local community. One relative told us, "It's the only time my [family member] is happy." Another relative told us, "The only time my [family member] comes out of their shell is at the day centre." However, people had not been able to attend the day centre during the week of the inspection because there were not enough staff. This meant that people were not always provided with sufficient meaningful stimulation and entertainment.

We saw little in people's care records or in their rooms to suggest that the staff provided people with support to pursue their own hobbies or interests. One person's relative said they were pleased that staff provided their family member with their favourite magazine. However, another person told us they had to ask a relative to bring in books for them as staff had not told them whether there were any books available in the home. One person's personal history in their care plan stated they were a Charlton Athletic fan but there was nothing to show that this interest was supported.

People and their relatives said they had not been given any information about how to complain or raise concerns. However, they said they would talk to staff and one relative said they would go to the deputy manager. The interim manager showed us a poster they had put up around the home, which was meant to tell people how to make a complaint. The information on this was not correct so people would not have known who to get in touch with.

Inadequate

Is the service well-led?

Our findings

Following our inspection in August 2014 we issued the provider with a compliance action because the system in place to analyse accidents and incidents was not used to improve the safety of people at risk of falls and injury.

During our inspection on 03 March 2015 the interim manager showed us that they had started to look at whether there was a pattern to the falls people had had. However, the record was only for the previous month and had not been completed. This meant that there was very little information available and no analysis had been carried out to reduce people's risk of harm. The provider had not achieved their action plan.

This was a continued breach of Regulation 10(2)(c)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a system in place to audit and monitor the quality of the service they were providing. One of the senior staff told us they carried out monthly audits of medicines, care plans and infection control. However, the medicines audit had not identified the lack of records of the amounts of medicines carried forward from the previous cycle. This meant that a complete audit of medicines in stock could not be undertaken.

People who lived at Symonds House had been given the opportunity to comment on the service they received by way of a formal questionnaire. One person had written they did not like being woken at 5:30am to get up. The same person had told us that this was still going on. This meant that no action had been taken to make the improvement this person had requested.

Staff meetings were held every six months. One member of staff told us about the meeting in October 2014 at which the then new manager had introduced staff to the changes they were planning to make. The member of staff told us, "These changes have gone off the boil now she has left." We saw minutes of the staff meeting held in October 2014 at which the manager at the time had reminded staff that people should not be referred to as 'patients'. However, during our inspection we heard people referred to as patients on a number of occasions by a senior member of staff who was therefore not acting as a good role model. This meant that staff meetings had not proved effective to change staff's practice.

As part of their system to audit and monitor the quality of the service being provided, the provider had contracted an independent care consultant to report on all aspects of the service being provided. The consultant had visited the home in August and November 2014 and their reports were available to the manager. They had found some of the issues that we found during this inspection, including that accidents and incidents were not collated and analysed. This meant that the provider's quality assurance system was not effective.

These matters were a 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.

The provider had not notified CQC about a serious injury to a person using the service, which they are required to do by law. We found that a person had been admitted to hospital with a fracture following a fall in mid-February 2015, but no notification had been sent to CQC.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff told us they enjoyed working at Symonds House. One said, "It's a nice job working here" and felt they were able to make suggestions for improvement. Another member of staff said, "I like working here, the staff are nice and the directors are helpful." A third member of staff felt that their suggestions and requests for improvements "fell on deaf ears." A senior member of staff told us that staff had a one-to-one supervision session every two months and one member of staff confirmed that they had supervision regularly. However, other staff told us they had 'never' had a supervision or 'not had one for months' and none of the staff could recall the last time (if ever) they had had an appraisal. This meant that staff were not fully supported to do the job they were employed to do.

There was no registered manager at Symonds House. The last registered manager, who had only been at the home for a few months, had left in October 2014. Another manager had been appointed. They had gone on leave in December 2014 and the deputy manager had managed the

Inadequate

Is the service well-led?

home in their absence until the beginning of February 2015. At the time of the inspection the home was being managed by an interim manager for two days a week. The interim manager was a registered manager in another of the provider's services.

People and relatives we met during the inspection seemed confused about who the manager was. They were surprised that managers had left and they had not been informed. Staff commented on the number of managers there had been at the home. One staff member told us they were frustrated by the frequent change of managers. Another said, "There have been so many managers and changes….staff have lacked consistency and direction." A third staff member explained, "New managers put processes in place which are unsustainable when they leave." Staff told us they were looking forward to some "security and consistency" when the new manager took up their post.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There was not a sufficient number of suitably qualified, skilled and experienced staff employed to meet people's needs. Regulation 22 This corresponds to regulation 18(1) of the HSCA 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Medicines were not managed in a way that ensured people were given their medicines safely and as prescribed. Regulation 13 This corresponds to regulation 12(1) and (2)(g) of the HSCA 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider did not have suitable arrangements in place for obtaining the consent of people who used the service in relation to the care provided for them. Regulation 18 This corresponds to regulation 11 of the HSCA 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider did not have suitable arrangements in place to ensure that staff were appropriately supported to ensure they put their training into practice. Regulation 23(1)(a) This corresponds to regulation 18(2)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People who used the service did not always have their privacy and dignity respected. Regulation 17(1)(a) and (2) This corresponds to regulation 10 of the HSCA 2008 (Regulated Activities) Regulations 2014
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People's personal records were not held securely. Regulation 20(1)(a) and (2)(a) This corresponds to regulation 17(1) and (2)(c) of the HSCA 2008 (Regulated Activities) Regulations 2014
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider did not have an effective system in place to monitor the quality of the service provided. Regulation 10

This section is primarily information for the provider

Action we have told the provider to take

This corresponds to regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not notified the Commission without delay of an incident affecting a person who used the service. Regulation 18(1) and (2)(a)(b)