Care One Limited

Abbey Care Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 13 January 2016 and was unannounced. Abbey Care Home provides accommodation and personal care and support for up to 11 older people, some who may be living with dementia. At the time of our inspection there were 9 people who lived in the service.

At this inspection we found the service had not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care. There were insufficient members of staff available to meet people's care needs and staff were not appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people safely. The service also did not assess and monitor the quality of service provision adequately this was with particular reference to areas relating to infection control and the environment.

People's safety was being compromised and they were at risk of harm because on going care was not being assessed and delivered which met their changing needs. Assessments of risk to people had been developed but not all had not been kept up to date. Some information

Summary of findings

was not current and staff were seen undertaking duties which contradicted the information in the plan of care. People did not always have their prescribed medicines administered safely.

Staff did not all have the knowledge and skills they needed to carry out their role and responsibilities effectively. They did not recognise poor practice which might put people at risk of injury, for example when supervising people where they required two staff to assist them, and only one staff member assisted them which meant guidance had not been followed appropriately. People were provided with sufficient quantities to eat and drink however meals were delayed at times due to a lack of staff available to help people who needed assistance.

People were not actively encouraged consistently to take part in activities that interested them and to maintain contacts with the local community due to staff constraints. Care records we viewed and our own observations did not show that wherever possible people were offered a variety of meaningful chosen social activities and interests and hobbies.

The service was not in all cases meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Although appropriate mental capacity assessments and best interest decisions had been undertaken by relevant professionals we were not assured that appropriate referrals had been made by the service. This would have ensured that the decision was taken in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated Codes of Practice. The Act, Safeguards and Codes of Practice are in place to protect the rights of adults by ensuring that if there is a need for restrictions on their freedom and liberty these are assessed and decided by appropriately trained professionals.

Systems were not fully in place to gain the views of people, their relatives and health or social care professionals. The provider had quality assurance systems in place to identify areas for improvement, however appropriate action to address any identified concerns had not always been taken. Audits, completed by the provider and registered manager and subsequent actions had not all resulted in improvements and proactive development of the service.

Staff interacted with people in a caring, respectful and professional manner. Where people were not always able to express their needs verbally we saw that staff responded to people's non-verbal requests and had a good understanding of people's individual care and support needs.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider had a good recruitment process in place. Records we looked at confirmed that staff were only employed within the home after all safety checks had been satisfactorily completed.

There were systems in place to manage concerns and complaints. No formal complaints had been received in the last year. Informal concerns received from people had been recorded and included the action taken in response. People understood how to make a complaint and were confident that actions would be taken to address their concerns.

No formal audits had been undertaken or were scheduled, to monitor the safety and suitability of the premises. The provider and manager were not able to provide any evidence that systems were in place to identify, assess and manage any risks related to the service. There were no systems in place to ensure an effective infection control programme was in place which was risk assessed and monitored to mitigate the risk of cross infection.

Effective quality assurance systems were not formally in place to identify areas for improvement and appropriate action to address any identified concerns. Audits, when completed by the registered manager and senior staff and subsequent actions had not resulted in improvements in the service.

You can see what action we told the provider to take at the back of the full version of the report summary.

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?

Inadequate

The service was not safe.

There were insufficient numbers of staff available to meet people's needs and to keep people safe.

Care records and risk assessments had not all been updated to reflect people's current changing health needs.

Staff knew how to recognise and report concerns of abuse. There were processes in place to listen to and address people's concerns.

Recruitment practices at the service were safe.

Infection control practices at the service were not consistently safe.

People did not always have their prescribed medicines administered safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

The provider did not fully ensure that people's needs were met by staff with the right skills and knowledge. Staff had not all got up to date training, supervision and opportunities for professional development.

People had their nutritional needs met.

Staff did not all have a good knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and how this Act applied to people in the service.

The environment at the service was not monitored sufficiently to be safe for people at all times.

Is the service caring?

Good

The service was caring.

Staff had a caring and supportive approach to the care they provided for people.

People were cared for by staff who knew them well.

People told us that staff respected their privacy and dignity and supported them to be involved in making decisions about their care.

People were positive about the care they received. People told us staff treated them with respect and we observed caring interactions between staff and people who used the service.

Summary of findings

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People had personalised care plans in place but these had not been regularly reviewed and updated.

People were not supported to make choices about how they spend their time and pursued their interests.

Appropriate systems were in place to manage complaints.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

The leadership of the service did not always recognise poor practice or

acknowledge where improvements were needed.

The registered manager supported staff at all times and was a visible presence in the service.

People were not always formally asked for their views.

The service did not have a fully effective quality assurance system. The quality and safety of the service provided was not being adequately monitored or reviewed fully.

Abbey Care 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.

The inspection took place on 13th January 2015 and was unannounced.

The inspection team consisted of two inspectors.

We reviewed the information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

We focused on speaking with people who lived at the service, speaking with staff and observing how people were cared for. Some people had complex needs and were not able, or chose not to talk to us. We used observation as our main tool to gather evidence of people's experiences of the service. We spent time observing care in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people who lived in the service, seven care staff members, two visiting relatives, the manager and the provider. We also attended a staff meeting that was being held that day.

We looked at four people's care records, four staff recruitment records, medication records, staffing rotas and records which related to how the service monitored staffing levels and the quality of the service. We also looked at information which related to the management of the service such as health and safety records, quality monitoring audits and records of complaints..

Inadequate

Is the service safe?

Our findings

Some people told us they felt safe. However, some people told us there were insufficient numbers of staff available to support them with their needs at all times. One person told us, “The staff get so busy sometimes. I don’t like to bother them.” And a relative told us “Although the staff are all very caring and they keep my [relative] safe. I do think they could do with an extra pair of hands at times.” Staff told us it can be quite hectic as there are only two staff working sometimes and one of those staff members does the cooking. We were also told by staff, “Residents are becoming more dependant so it can be stretched at times.”

On the day of our inspection there was only two members of staff on duty to provide care for ten people. At least three of these people required the assistance of two staff members all the time for help with eating and mobilising. The manager was also on duty with a cleaner. Two people regularly needed assistance to go outside for a cigarette. This meant that the staff member left supporting the other people at the service at the time, would not be able to respond to people’s needs if they required more than one staff member’s support. The manager was supernumery which meant they were not included in the staff numbers allocated to provide care, however was noted to be helping people directly and was therefore unable to fulfil their management tasks fully.

Staff told us that it was difficult to provide assistance to people in a timely manner due to a lack of staff which they had highlighted to the provider before, however this had, as one staff member told us, “Not been acknowledged.” For example, we saw one person who had been assessed as being at risk of falls sat in the lounge area most of the day. There was little engagement or help offered. We noted on a couple of occasions this person went to get out of their chair independently, however with no staff in the lounge at that time, was at risk of falling. During our lunchtime observations we noted a drink was spilt by this person and the inspector needed to intervene as there were no staff available. The inspector waited for at least five minutes and then had to go and search for staff. One staff member was in the kitchen talking to the manager and another was fetching ice cream from an outside store. The staff member in the kitchen was doing the cooking. The person who spilt the drink was noted to need two staff to mobilise out of their chair to change their wet clothes after spilling their drink, this left no staff available to assist other people.

In another case a person who had problems mobilising was noted to require help to return them to their room. This person also had some specialist needs in relation to eating and drinking and mobilising independently. The care documentation stated that they required the assistance of two staff at all times to mobilise and had swallowing difficulties and therefore needed to be supervised. Only one staff member was observed assisting this person which contradicted the guidance given directly in the plan of care.They then left the lounge area so there were no staff present and no call bells visible or accessible to people in the lounge to call for staff assistance.

A SOFI observation undertaken at lunchtime revealed the following. There were only three people eating in the dining room, there was a choice of juice to drink but it was placed on the side and not on the table where people were eating. People were given serviettes, cutlery and a glass but no condiments were on the table. Staff served the food then left the dining room so there was minimal staff presence in the dining room during the meal. People were eating independently but minimal interaction was observed. Staff did not offer or pour out a drink for the three people in the dining room. Additionally one person became irritated by another who was making rude facial gestures towards them, At one point an elbowing gesture was made by one of the people but did not make contact. No staff were present at the time this was happening to mitigate any risk of any harm happening. Staff presence was minimal and they were not aware it was happening. Staff remained unaware of this incident happening until the inspector made them aware of it. Another person also sitting at the table noticed that the person they were sat next to was trying to eat with two spoons and told them this in quite a stern way. They then got up to go and get the jug of juice as they had been waiting for a drink for over 10 minutes. The staff member who had been outside noticed this at this point and immediately said, “I will do it.” They took the jug of juice from them and then poured a drink for everyone. When the staff member did come into the dining area to collect plates they were polite and friendly but interaction was not sustained and they left straight away.

Inadequate

Is the service safe?

In the lounge area it was noted that three people were eating from small tables when there was sufficient space in the dining area. No one was consulted about where they would like to eat. Two people required assistance to eat and only one member of staff was noted to do this, and as each person required the assistance of one staff member, one person in the lounge area therefore had to wait to eat their meal. Additionally we observed one other person ate in their room on the day of inspection and also needed the assistance of one member of staff. This meant that overall three staff members were required to help everyone and only two were available. This clearly showed that there were not enough staff to attend to everyone's needs during the mealtime.

Two people chose to smoke cigarettes and required assistance to go outside. One person stated they had to wait usually as there were not enough staff to help them and they needed someone to stay with them due to having sight problems.

The provider was unable to demonstrate how staffing levels were reviewed to ensure there were sufficient staff available. Staffing numbers had been calculated according to the number of people using the service rather than against individual needs which varied. Some staff told us they had been working additional shifts to help out and one told us, "We have helped out when other staff are sick or off."

We were advised in October 2015 of a medication error as part of a safeguarding referral made to us. This detailed that one person had missed a dose of medicine and this had been given later in the day due to a staff member being called away to help another person. The provider had failed to report this to CQC and the manager advised that the error related to the staff member being 'busy'. This showed that the lack of sufficient staff numbers could place people at risk of missing medication to ensure they are well at the correct times. We also found out as a result of this inspection that in December 2015 the service had also failed to advise us of the short absconsion of someone from the home. This showed that supervision of people was not adequate and there were not enough staff on duty to keep people safe that at that time.

We identified that the service was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's safeguarding adults and whistle blowing procedures provided guidance to staff on their responsibilities to ensure that people were protected from abuse. Staff understood the procedures to follow if they witnessed or had an allegation of abuse reported to them. Staff told us they had received training in safeguarding adults from abuse. They also told us that they were confident and knew how to support people in a safe and dignified manner. Safeguarding referrals and alerts had been made where necessary and the service had cooperated fully with any investigations undertaken by the Local Authority. Where safeguarding referrals had been made we saw records had been maintained with regard to these.

Risks to people's safety had been assessed. Risk assessments covered areas such as; the safe moving and handling of people, nutrition and dehydration risks and prevention of pressure ulcers. Care plans contained some guidance for staff which described the steps they should take when supporting people. Our observations and conversations with staff did not always demonstrate that guidance had been followed.

All staff had received training in the safeguarding of adults from abuse. Staff knew how to recognise signs of harm and knew who to report any concerns to. One staff member told us, "I would report anything like that, I am confident reporting of any concerns or suspected abuse. I think its important." The provider had up to date policies which included safeguarding adults and whistleblowing. Staff were able to demonstrate their awareness of the whistleblowing policy and who to report their concerns to.

Risk assessments for the location and environment had been formulated and we saw that there had been appropriate monitoring of accidents and incidents. Appropriate plans were also in place in case of emergencies, for example, evacuation procedures in the event of a fire.

The provider had a safe system in place for the recruitment and selection of staff. This ensured that staff recruited had the right skills and experience to work at the service. Staff told us that they had been offered employment once all the relevant checks had been completed. This meant that people could be confident that they were cared for by staff who were safe to work with people who lived in the service.

Inadequate

Is the service safe?

Medication was stored safely. We observed medication being given to people at the lunch time, and although this was done with due care and safely we noted one person made an active choice to save their pain relief until later in the day. This was just left in a pot on the persons bedside cabinet. Whilst we acknowledge that this was the person's own choice we reminded staff and the manager of the safety implications of medication being left in a pot by the bed with other confused people in the service who may accidentally access it. The person concerned said, "I usually put it in my drawer and forgot." The manager also confirmed they had spoken to the person concerned and the staff member to ensure medication was given and recorded at the correct time to ensure accuracy and that no medication errors were made. Regular medication audits were completed to check that medicines were obtained, stored, administered and disposed of appropriately. Staff had received up to date medication training and had completed competency assessments to evidence they had the skills needed to administer medicines safely.

Requires improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the Mental capacity Act (2005) MCA. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When a person lacks mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager told us that two DoLS applications had been made in April 2015 and none had been authorised yet so were still not in place. The manager also told us that they could not access or provide paperwork to support this as the provider had renewed the computer system and the files were now inaccessible. No proactive follow up of the applications that had been made, was evident either. There were also insufficient records to show that staff had attended training in relation to DoLS. Staff we spoke with were not all sure that they had attended training regarding this. Some staff we spoke with had a basic knowledge of DoLS, however others lacked understanding regarding the process and which people within the home DoLS related to. For instance one staff member told us that a best interests decision was just as good. This meant that people were at risk of having their liberty restricted unlawfully as there was a lack of knowledge and understanding regarding DoLS within the staff team. There were no records to view and as part of this inspection we identified at least two people who should have had a DoLS in place.

The provider was not supporting staff by ensuring they received consistently regular supervision, training and development.This meant they were not always able to deliver care and treatment to people safely and to an appropriate and required standard. The provision of supervision and appraisal had not always been delivered in a timely and appropriate manner. The manager confirmed that supervisions and appraisals for some staff had lapsed. One staff member told us, “We have not had any supervisions recently I cannot remember when my last one was.” Staff meetings were held and we observed one that took place on the day we inspected. The meeting did not last long on this occasion as the inspection was in progress, and meeting minutes and notes were not available for any previous meetings held.

We observed a member of staff help mobilise a person on their own when the care plan for this person stated that they should be supported by two staff at all times for their safety. Staff told us they had completed any practical moving and handling courses required. The staff member did not follow a safe process when supporting this person because they had not followed the appropriate practical guidance to do so. The manager told us that external moving and handling courses were held but since they were not part of a consortium any more these were more infrequent. This placed the person’s safety at risk. We also noted that other specialist training courses had lapsed and the manager told us a review of all staff training was required. Staff had not all been provided with updated training that gave them the skills, knowledge and qualifications to ensure people’s needs were being met. As a result the staff could not demonstrate a consistent approach to supporting people.

Staff told us they did not feel the training they received was wholly adequate to ensure they could competently understand fully people’s needs. This was particularly prominent in relation to staff knowledge around the Mental Capacity Act and Deprivation of Liberty. Most of the training staff received was provided internally by the provider and staff advised us that they attended very few external training courses. One staff member told us, “We have a lot of training given to us by the provider and I don’t gain enough from that to do my job properly.” Another staff member said, “We complete e learning and a workbook for distance courses as well but I like the courses where you can sit and learn in a group setting.” Not considering staff’s concerns about how they experienced the training provided, and the lack of practical training meant that staff were not confident in their duties and placed people’s wellbeing at risk. We found that the training provided did not adequately match the health and care needs of the people using the service. At least two people had specialist healthcare needs or exhibited challenging behaviour. Not all staff had received training in dealing with people’s behaviour which could place others at risk, supporting people’s mental health needs or needs related to specialist

Is the service effective?

healthcare needs. This lack of training and guidance placed people at potential risk. We did note that all staff had started or were waiting to start an NVQ (National Vocational Qualification) or the skills for care certificate.

We identified that the service was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw as part of this inspection a new extension had been built to accommodate a further 10 people with mental health needs. The provider advised us that these were his intentions however this building has not yet been registered with the CQC. Prior to our inspection we were informed by a whistle blower in October 2015 that people who were confused were freely accessing the new extension unsafely as the door in between was not locked. We were also told that builders were accessing the occupied building and using the bathroom facilities. Two people raised concerns with us about this at this inspection and said they had been told the provider intended to admit people with mental health needs.

We were also advised that there were insufficient cleaning materials for staff to use (and those, they had, were of an inadequate standard – for example toilet rolls) staff to use and the staff toilet had a broken flush. We advised the manager of our concerns and the door was then secured and builders were advised not to enter the occupied part of the building without permission or at any time to use the shower facilities. Whilst we acknowledge that improvements have been made to the environment, during this inspection we noted that there were areas of the service still in disrepair and that could present as a hazard to people. Examples of these were floors that were uneven and potential trip hazards. Flooring in the existing home were very uneven, which meant that one person had to wait for staff as they did not feel comfortable walking independently. Also a raised step area to back garden meant another person required assistance to negotiate this due to having sight difficulties and another because they were at risk of falls.

There was inadequate lighting in areas of the service with no automatic switching system. Some corridors and stairways are very dark which meant people could not see properly in that area and were at risk of having an accident. One person directly raised concerns about this and said. “I don’t walk down that corridor without someone as I worry about having an accident.” They also said, “It is not really built for a blind person as the floors are quite uneven and the light is dim. I have to wait for staff to help me walk as I cannot move around on my own in here.” None of this was considered in relation to individual’s safety and suitability on admission. The care plan for this person also identified the need for areas to be well lit and free from obstacles.

We noted other disrepair in the service. One shared room we saw presented with mismatched furniture and a broken chest of drawers. The wardrobe handle was broken, and one of the beds although useable, resembled a wooden temporary bed. In another room we noted that a carpet needed replacing due to some damage caused by the person who used it. Another room we saw was quite bare but had some offensive odours present.

One stairway went up round a corner with a handrail, and one person was observed to struggle with this. No staff were available at all times to observe or monitor this.

The staff toilet was unhygienic and not usable. There was a sodden carpet caused by a leak from above. It had an offensive odour and the ceiling was discoloured and soaked with mould. The flush was also still broken. The staff toilet opened directly onto a communal corridor with people’s bedrooms next to it and emitted an unpleasant smell every time the door was opened. We ascertained that the leak was due to a possible leak from room above. When we checked the room it had an offensive urine odour and there were clear cleanliness problems around the floor of the bathroom below the toilet.

Additionally we saw that one person who had a condition which meant that they crawled on the floor to mobilise. No thought had been given to any regular cleaning schedule of the carpets or the removal of visitors and staff footwear to mitigate the risk of spreading cross infection from the outside in. this was particularly relevant to the staff toilet which had a carpet soaked in a unknown substance. Staff were also not aware of the potential effects of this as they were seen to be walking in and out of the service all day with the same shoes on.

No audits had been undertaken or were scheduled, to monitor the safety and suitability of the premises. The manager was not able to provide any evidence that systems were in place to identify, assess and manage any risks related to the service. There were no systems in place to ensure an effective infection control programme was in place which was risk assessed and monitored to mitigate

Requires improvement

Is the service effective?

the risk of cross infection. Staff had no recent record of infection control training and no audits of infection control were seen to be in place. None of the people we spoke with were aware of any hand sanitisers and one person commented to us about the poor cleanliness of the building and the smell from the toilet. The service is failing to protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by not having an effective operation of systems designed to enable you to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

We identified that the service was in breach of regulation 12 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people and their relatives we spoke with were complimentary about the service they received and the manner in which staff supported them. They told us that they felt staff knew their relative well and had the ability to communicate effectively with people who may be living with dementia. One person told us, “The staff are very caring with [relative] and know what to do.”

Most staff told us that they were supported with supervision, which included guidance on things they were doing well. It also focused on development in their role and any further training that would benefit them. Staff also attended staff meetings where they could discuss both matters that affected them and the care management and welfare of the people who lived in the service. Staff told us morale was good and although they felt the staff meeting on the day of inspection was brief they all felt able to approach the Manager at any time. Staff told us they used a handover book to record anything the next shift might need to know.

We saw people had been consulted and consented to their plans of care. Person centred support plans were developed with each person which involved consultation with all interested parties who were acting in the individual's best interest. One relative told us, “[Relative] has dementia and the home involve me in many decisions relating to them.”

People were complimentary about the food. They told us they had enough to eat, their personal preferences were taken into account and there was a choice of options at meal times. Suitable arrangements were in place that supported people to eat and drink and to maintain a balanced diet. People were not rushed to eat their meals and staff used positive comments to prompt and encourage individuals to eat and drink well. The lack of staff availability to help people who required assistance meant that some people had to wait long periods for assistance. One person told us, “The staff always help me and [staff member doing the cooking] is a very good cook. I do sometimes get a choice but today they did not ask as they know I really like sausages.” Another person said, There is not often much to do here but the food is good and I like the traditional roasts. We always get a good dessert here.”

The service appropriately assessed people’s nutritional status and used the Malnutrition Universal Screening Tool (MUST) to identify anyone who may need additional support with their diet such as high calorie drinks or specialist diets. These assessments were up to date and had been reviewed on a regular basis. People had been regularly weighed and where necessary referrals had been made to relevant health care professionals for issues around swallowing, or dietetic services for people with particular dietary requirements.

People’s day to day health needs were being met and they had access to healthcare professionals according to their specific needs. The service had regular contact with GP support and healthcare professionals that provided support and assisted the staff in the maintenance of people’s healthcare. These included district nurses, the chiropodist, dietician, speech and language therapists (SALT) and social workers. People were encouraged to discuss their health. Regular reviews were carried out by health professionals to monitor improvements or changes that may require further professional input.

Good

Is the service caring?

Our findings

All of the people we spoke with, including the relatives, told us the staff were caring and kind. During this inspection we observed positive interactions between staff and people living at Abbey Care Home. People told us, "The staff are very good." And, "Staff are okay they help me when I need help." Relatives we spoke with agreed that staff were caring and treated people with respect. One staff member told us, "We all look after the people here, like they are our family. Some people have been here a long time."

The atmosphere in the service was calm and relaxed. We observed staff talking to people in a kind compassionate way. Staff knew people well and chatted to them about their interests and family members, whilst they provided support. We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering and referring to people by their preferred name. We saw staff were gentle and patient in their approach. When staff spoke with people they called them by name and either sat down next to them or knelt down so they were on the same level. Personal care activities were carried out in private. We observed staff offering reassurance when supporting people, such as when assisting a person to mobilise between rooms and negotiate a step. A staff member explained how they were going to support the person and reassured them throughout the transfer.

Staff told us that they respected people's choices around meals and activities and we observed this throughout the day. Staff listened to people, showing empathy and understanding, giving them time to process information and waited for a response without rushing them. We saw staff offered people choices, supported them in making decisions and respected their responses. For example, during the morning we observed one staff member going around asking people what they wanted for lunch and also at lunchtime when offering choices of dessert. They sat down with one person they were assisting in the lounge and started a conversation about the food, the staff member engaged well with the person whilst supporting them to choose their preferred meal. People told us they were treated with dignity and respect. One person told us, "I get choices offered to me like what I want for dessert." One visitor told us they had been involved in the care planning of their relative.

Staff we spoke with were able to tell us about people's individual needs and preferences and understood the importance of supporting people to keep their independence. For example, they told us one person needed support to wash and dress but was able to help wash the top half of their body and brush their teeth with prompts from staff. Another example was that of one person who had not wanted to engage with staff particularly well on admission to the service. but was now more accepting of staff encouraging them to be more independent and their challenging behaviour had settled. Staff we spoke with had a good understanding of people's needs and preferences. For instance, one staff member told us a person preferred female staff to support them and another member of staff told us in detail how a person was supported in line with their preferences.

Staff told us they were allocated their area of work each day which meant they got to know about everyone who lived at the home and their individual needs and preferences. They said they all worked well together and did not have a formalised key worker system, where staff take on extra responsibilities for small groups of people.

We observed the service had a culture which focused on providing people with care which was personalised to the individual. Staff were dedicated and caring. We observed relatives visiting throughout the day and the manager told us there were no restrictions in visiting times, encouraging relationships to be maintained. People we spoke with told us they could have visitors at any time and visitors we spoke with agreed. One visitor told us they were always, "Made welcome and can come at any time."

Requires improvement

Is the service responsive?

Our findings

We asked people to tell us about the social aspects of the service. An activities co-ordinator had not been employed. We asked people how they spent their day, some people told us there was nothing to do. A person said, "I'm okay but there is not much to do here I would like to go out more. The staff do their best but they are very busy." One person stayed in their room which was their preference. People said they watched television or went out with family.

People told us they would prefer more things to do. We saw as part of our observations a game of bowling was being played with four people and one staff member in the morning of our inspection. This however did not last long and one person told us, "This is not usual it is probably because you are here." Throughout our observations throughout the day we noted in the communal areas there was very little stimulation and interaction from staff during the day.

Families we spoke with confirmed they did not see many activities taking place however one relative told us, "I take my [relative] out but they do some painting with people and in the summer they do get them out in the garden. We had a great Christmas party."

Staff also said there were not the resources available to ensure quality activities took place. We did not see any evidence of activities or sensory equipment to support people living with dementia. Staff told us trips out rarely happened. People told us staff were constantly busy so did not have time to sit and chat for long periods. A person said, "The staff are good here but there's just not enough of them sometimes."

We identified that the service was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most care plans we looked at were reviewed regularly, this ensured people's current needs were documented and staff had guidance on how to support people. However, one care plan we looked at, because the person themselves had highlighted that they felt unsafe mobilising independently, had very little detail in their care plan in relation to their care needs or how staff should meet them. There was a section relating to their sight difficulties and eating and drinking which stated they were independent however needed assistance at times. Their care assessment stated they were at risk of falls and they needed two people at all times to mobilise but there was no falls history recorded and there was nothing recorded in regards to how staff should mitigate the risk of falls. This meant there was a risk the plan did not include information that reflected the person's current care needs in this area.

Care plans provided information in areas such as skin integrity, personal care, mobility and nutrition. Some plans we viewed were detailed and specific to the person. For instance, we viewed one care plan that provided detailed information on how to support a person who could display behaviours that challenge. The plan guided staff on techniques to support the person during those times and maintain their safety and wellbeing. They also contained information regarding people's family and their preferences in relation to some aspects of care and support. This enabled staff to get to know the person and provide care specific to the individual.

Other care files we observed included areas of conflicting information on how to support a person with their care needs. For instance one file contained a plan regarding someone who should be supported with two staff members at all times however the staff practice observed contradicted this when only one person helped this person. Staff we spoke with however, were clear about this person's needs and told us, "We don't have enough staff. "Another care file evidenced that a person required support with their nutritional intake, however a risk assessment indicated that the person was independent with their meals. Staff we spoke with were aware of the person's needs and confirmed that the individual did require some support when eating meals. This meant there was a risk staff may not be provided with clear guidance regarding people's care needs.

We identified that the service was in breach of regulation 17 (1) & (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were involved with their care planning. Records we viewed showed that when people were able, they had been involved in developing their care plans and people had signed to evidence their agreement with plans in place. Other care files evidenced that people's relatives had been consulted with regards to the care plan in place.

Requires improvement

Is the service responsive?

One care file recorded that the person was unable to be involved in the development of their plan of care, however there was no evidence that their care had been discussed with their family. Relatives we spoke with told us staff kept them informed of any changes regarding their relatives health and care needs.

Staff we spoke with told us they were informed of any changes within the service, including changes in people's care needs. This was achieved through staff handover as well as reading people's care plans.

Relatives told us that people's changing care needs had been identified promptly, and were regularly reviewed with the involvement of the person and or their relatives. One relative told us, "There are nurses that visit every day. The home has organised [relative's] blood tests for their Warfarin which has been helpful."

Some people told us they had choice as to how they spent their day, such as where to eat their meals, whether to sit in lounges or spend time in their rooms. Care files evidenced people's choice with regards to their daily routines, such as when to go to bed. Staff we spoke with agreed that people could make choices, and that these were respected.

Staff were aware of the actions that they should take if anyone wanted to make a complaint. People had access to a complaints' procedure and this was displayed on notice boards within the service. We looked at the complaints record, which showed that any complaints received, were addressed by the manager and that complainants were happy with the outcome. People we spoke with told us they did not have any complaints but would speak with staff or the manager if they did. People told us they would be listened to and relatives we spoke with agreed that any concerns could be raised and would be addressed. One relative told us, "I have not had any real cause to complain but I would go and see the manager straight away. I think the staff know what they are doing and I have not seen anything that would worry me."

Requires improvement

Is the service well-led?

Our findings

We found on inspection that two issues requiring the service to notify the Care Quality Commission (CQC) had not been made. These notifications were in relation to an allegation of abuse and for someone who had absconded from the service albeit for a short time. The allegation had subsequently been referred to the local safeguarding team as required by CQC, for investigation.

The provider confirmed that these had happened but that each person had not suffered any ill health as a result of the incidences and that is why they had not thought it necessary to inform us of the incident. We requested some additional information to enable us to make a judgement about this. These incidents were not analysed as incidents that had the potential to result in harm to a service user. Information and changes were not made to relevant procedures including medication, incident reporting and people's risk assessments and care plans. The service is failing to make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to the analysis of incidents that resulted in, or had the potential to result in, harm to a service user

We could not ascertain clearly that other required notifications had been made, such as those relating to deprivation of liberty safeguard authorisations.

We identified that the service was in breach of regulation 20 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always fully supported with training to make sure their knowledge and skills were up to date in particular when supporting people living with dementia and around important areas such as the Mental Capacity Act. The provider had failed to ensure all staff providing care, treatment and support to service users had the qualifications, competence, skills and experience to do so safely during our inspection on the 13 January 2016 we observed some poor manual handling practice. Staff training had been provided but there were no assessments of staff's competence and the training was not of a sufficiently high standard. During our inspection we identified poor manual handling practices and staff failing to keep people safe.

No formal audits had been undertaken or were scheduled, to monitor the safety and suitability of the premises. The provider and manager were not able to provide any evidence that systems were in place to identify, assess and manage any risks related to the service. There were no systems in place to ensure an effective infection control programme was in place which was risk assessed and monitored to mitigate the risk of cross infection.

Effective quality assurance systems were not formally in place to identify areas for improvement and appropriate action to address any identified concerns. Audits, when completed by the registered manager and senior staff and subsequent actions had not resulted in improvements in the service.

We identified that the service was in breach of regulation 17 (1) & (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people living at the home their views of how the service was managed. People and their relatives told us they all had a lot of confidence in the manager and staff. All the people we spoke with told us they knew who the manager was and comments included, "She is fantastic; I came here just to work with her as I had worked with her in a previous home." People spoke warmly about the manager. The manager told us that she found her job difficult and, "Had to fight to get things done." As she felt she was not always listened to by the provider. Some staff said they were looking for alternative employment as they did not feel supported by the provider.

In addition, we asked families their views of the leadership and management of the service. Families were positive about the staff and manager. A family member said to us, "We always see the manager around she is very kind and helps." Staff were not so positive about the provider and we were told, "We don't see the owner very much."

All of the staff told us they worked in a friendly and supportive team. One told us. "We all work well together." They felt supported by the manager and they were confident that any issues they raised would be dealt with. Staff felt able to raise concerns with their manager and felt listened to by both manager and colleagues. Staff felt able to suggest ideas for improvement, and that communication was always inclusive.

Staff said they were aware of the whistle blowing process within the service and said they would not hesitate to

Requires improvement

Is the service well-led?

report any concerns or poor practice. A member of staff said the culture was open enough to question practice. Staff understood their roles, responsibilities and own accountability, and the service maintained links with the local community. We saw that people accessed the community however there was not good staff availability to enable any outings and service events to take place on a regular basis and the service links with the community were good.

We asked staff what the home did well and they consistently told us they worked well together as a team and supported each other. Equally, we asked staff how the home could be improved. We had varied responses, which included improved staff levels, new furniture and improvements to the environment, more resources and staff support.

We asked people living at the home and their families how management involved them in sharing their views about the development of the home and how it could be improved. Everyone we spoke with was unaware of any formal processes to share their views about the home. They said they had not been invited to any meetings or asked to complete any satisfaction questionnaires. There were no meeting minutes to review and there were no copies of the questionnaire survey the service used displayed on the noticeboard for people to complete. Although we asked, we were provided with no evidence that a satisfaction survey had been completed within the last 12 months.

We asked staff how service developments and changes were communicated with them. Staff told us meetings were held periodically.

There was a diverse mix of people living at the service. Our registration records for the service indicate that the service was registered to provide accommodation and care for older people living with dementia. This was confirmed by the statement of purpose (description of the service). However, there were also people living there who did not have a diagnosis of dementia but had needs associated with complex physical disabilities and the provider also made us aware he intended to register the new part of the building for people with mental health needs. We raised concerns with the provider about the diverse group of people the service was to provide a service for and the appropriateness of the same. The 'service user band' for the home was for people with dementia and did not indicate that the service took people with more complex conditions. No risk assessment had been undertaken regarding this diverse client group mix and staff had not been provided with any specific training required to meet the needs of the people.

We were informed that the provider and manager undertook regular audits. Although we asked for copies of these, we were not provided with them during the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person had not ensured systems and processes were established and operated effectively to ensure compliance. This was in breach of regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 - Good Governance How the regulation was not being met: The registered person did not ensure systems and processes were established and operated effectively to ensure compliance, and in order to meet the provision of the regulated activity. Regulation 17 (1) and (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour Regulation 20 HSCA (RA) Regulations 2014 Duty of Candour **We found that the registered person had not ensured systems and processes were established and operated effectively to ensure compliance. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2014 – Duty of Candour How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered person failed to advise us of notifiable incidents as required by law to ensure compliance, and in order to meet the provision of the regulated activity. Regulation 20
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing **We found that the registered person had not protected people against the risk of insufficient staffing levels. This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 – Staffing How the regulation was not being met : The registered person did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed in order to meet the provision of the regulated activity. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe Care And Treatment **We found that the registered person had not protected people against the risk of unsafe care and treatment. This was in breach of regulation 12 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 – Safe Care And Treatment How the regulation was not being met : The registered person did not ensure that care and treatment was provided in a safe way for service users at all times in relation to staff training, the environment and infection control in in order to meet the provision of the regulated activity. Regulation 12 (1) and (2)

The enforcement action we took:
We served the provider and manager with a warning notice to be met by **30th May 2016**