Littleton Holdings Limited

Samuel Hobson House

Inspection report

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Ratings

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

Overall summary

We inspected Samuel Hobson House on 11 November 2014. Samuel Hobson House is registered to provide accommodation and personal care for up to 39 people. People who use the service have physical health and/or mental health needs, such as dementia.

At the time of our inspection accommodation and care was provided to 22 people.

There was no registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The staff told us that the previous registered manager had left the service approximately two weeks before our inspection. Following our inspection, the provider contacted us to inform us they had recruited a new manager. We were not informed if the new manager was planning to register with us.

Summary of findings

At the last inspection on 18 March 2014 we asked the provider to make improvements. These were in relation to the content and accuracy of the information contained in people's care records and how the quality of care was assessed and monitored.

During this inspection we found that the provider had failed to make the required improvements. This meant the provider had continued not to meet the standards required to meet people's care and welfare needs.

At this inspection, we also identified additional areas of unsafe, ineffective and unresponsive care. This was because the service was not well led. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed and people did not always receive their care in accordance with their care plans. This meant people were not always kept safe and their welfare and wellbeing was not consistently promoted.

There were insufficient numbers of staff to keep people safe and provide the right care at the right time. This also meant that people's individual needs were not always met and the staff did not have time to consistently treat people with dignity and compassion.

People's care records were not always accurate, up to date or secure. Information about people's needs was not always available for the staff to use. This meant people were at risk of receiving unsafe or unsuitable care.

People were not consistently offered choices about their care and care records did not always contain information about people's care preferences. This meant there was a risk that people's care preferences may not be met.

People did not always receive the support they required to eat and drink in accordance with their care plans. This meant that people's risks of malnutrition and dehydration were not always managed.

Some people who used the service were unable to make certain decisions about their care. In these circumstances the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were not being followed. The Mental Capacity Act 2005 and the DoLS set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. This meant people could not be assured that decisions were being made in their best interests when they were unable to make decisions for themselves.

There were gaps in the staff's knowledge and skills because the staff's training needs had not been assessed and managed. This meant people received inconsistent and unsuitable care from the staff.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

Effective systems were not in place to seek people's views about the care. This meant that people's views were not sought to make improvements to the care.

Systems were in place to store, administer and record people's medicines. However people's medicines were not always given in a manner that ensured their safety.

People were supported to access health and social care professionals, but improvements were required to ensure referrals for advice and support were made in a timely manner.

People and their relatives told us the staff were friendly and caring and we saw that people's privacy was promoted by the staff. Relatives told us they were happy with how the staff communicated changes in people's needs and they understood how to complain if they needed to share concerns about care.

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. Risks to people's health and wellbeing were not consistently identified, managed and reviewed. This meant people's safety and welfare was not always promoted.

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

People's care records were not always accurate, up to date or secure. This meant information about people's needs was not always available for the staff to use. This meant people were at risk of receiving inconsistent and unsafe care.

Is the service effective?

Inadequate 

The service was not effective. Consent to care was not sought in line with legislation and guidance. This meant people could not be assured that decisions were being made in their best interests when they were unable to make decisions for themselves.

Some people were prevented from leaving the service when they requested to leave. The legal requirements in place to ensure people were restricted to the confines of the service were not followed. This meant people could not be assured that they were being prevented from leaving the home in a lawful manner

People did not always receive the support they required to eat and drink in accordance with their care plans. This meant that people's risks of malnutrition and dehydration were not always managed.

There were gaps in the staff's knowledge and skills because suitable training had not been provided. This meant people received inconsistent and unsuitable care.

Is the service caring?

Requires Improvement 

The service was not consistently caring. People were not always offered choices about their care. This meant there was a risk that people's care preferences may not be met.

The staff did not always have the time to treat people with dignity and compassion.

People and their relatives told us the staff were friendly and caring. People's privacy was promoted by the staff.

Summary of findings

Is the service responsive?

Requires Improvement 

The service was not consistently responsive. There were insufficient numbers of staff to meet people's needs in a timely manner and people were not consistently enabled to participate in their preferred leisure and social based activities.

People's care preferences were not always recorded. Information about people's likes and dislikes was not always available for the staff to follow. This meant people were at risk of receiving inconsistent or unsuitable care.

People's relatives were happy with how the staff communicated changes and involved them in the planning of care. Relatives understood how to complain if they needed to share concerns about care.

Is the service well-led?

Inadequate 

The service was not well led. The required improvements from our last inspection had not been made. This meant the provider had continued not to meet the standards required to meet people's care and welfare needs.

Effective systems were not in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

Staff told us that interactions with the provider were not always positive. This meant there was a risk that staff would not report poor or unsafe care to the provider.

Samuel Hobson House

Detailed findings

Background to this inspection

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

This inspection took place on 11 November 2014 and was unannounced.

Our inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of older people and people living with dementia.

Before the inspection, the provider was sent a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider did not submit a completed PIR to us.

We checked the information we held about the service and the provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public and the local authority. We used this information to formulate our inspection plan.

We spoke with seven people who used the service and five relatives. We did this to gain people's views about the care. We also spoke with five members of care staff, the deputy manager and the principal care home manager (The person who managed the overall running of the provider's services. This person was not registered with us). This was to check that standards of care were being met.

We 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 looked at eight people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, health and safety checks, staff rotas, training records, five staff recruitment files and minutes of meetings.

Following our inspection we made four referrals to the local authority's safeguarding team. We did this because of the concerns we identified with people's care.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that effective systems were not in place to keep people safe. We saw that people's care records did not always provide staff with the information they needed to keep people safe. We told the provider that they needed to make improvements to ensure people's care records were accurate and up to date.

At this inspection, we found that records were still not accurate and up to date. For example, we saw that no records were being kept to confirm that one person had received their dietary supplements in accordance with medical advice. The care staff we spoke with confirmed they were not recording this. One staff member said, "I've asked for a blank supplements chart for days now. There's nowhere for us to record it". This meant accurate records were not being kept to show that the person was receiving their agreed care.

We also saw that care records were not always stored securely. The records cupboard in the upstairs dining room was unlocked for the duration of our inspection. We saw that people's daily records were left on top of the dining table or the records cupboard unsupervised on four separate occasions. On one occasion we found a person who used the service moving the care records of six service users whilst holding a cup of tea. This meant that people's personal information was not kept safe and care records were not protected from the risk of being damaged, destroyed or misplaced.

The provider's failure to keep accurate, up to date care records and not storing records securely was a continued breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The risks of harm to people who used the service were not consistently identified or managed to promote their safety. For example, we observed one person walking using a broken mobility aid. This meant the stability and safety of the aid was compromised. The aid also had an exposed broken hinge which posed an additional risk of skin damage to the person who used the aid and the other people who used the service. The staff we spoke with were aware that the aid was broken. One staff member said, "They [The person who used the service] came with it like that". The deputy manager confirmed that no risk assessment had been completed to demonstrate that the risks of using this broken mobility aid had been assessed. They also confirmed that no professional advice had been sought from a physiotherapist to ensure the safety of the person who used the aid. This meant there had been a failure to identify, assess and manage this risk. Therefore this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that where risks had been identified people did not consistently receive their care in accordance with their care plans. For example, care records showed and staff confirmed that two people were not supported in accordance with their care plans to change their position to manage their risk of skin damage. This meant that these people did not receive their planned care to ensure their welfare and safety.

People's risks were not consistently reviewed to ensure the plans in place to manage their risks were current and reflected their changing needs. For example, one person's care records showed they were at risk of rolling out of their bed. A risk management plan was in place that stated, '[The person who used the service] requires a lower bed to reduce the risk of injury'. We saw that this person did not have a low bed in their bedroom. The deputy manager told us that the low bed was replaced with a higher bed to accommodate the use of a hoist. No review or reassessment of the risk of rolling out of the bed had been completed following the change in bed. This meant that the person could not be assured that their risks were being managed to ensure their safety and welfare.

The provider's failure to manage and review people's risks did not ensure the welfare and safety of the people who used the service. Therefore this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff we spoke with explained how they would recognise and report abuse and we saw that any identified suspected abuse was reported in accordance with the local reporting procedures. However people were not protected from avoidable harm in the form of neglect. During our inspection, we identified that two people had remained seated in communal areas of the home for periods of nine and a half hours and ten hours without being supported to change their position or receive assistance to go to the toilet. One of these people's care records showed they were at risk of skin damage. The 2014 National Institute for Health and Care and Excellence (NICE) guidelines on the

Is the service safe?

prevention and management of pressure ulcers states, 'Encourage adults who have been assessed as being at risk of developing a pressure ulcer to change their position frequently and at least every six hours'. This meant that this person's care did not reflect expert and best practice guidance in order to ensure their safety and welfare. Therefore this was an additional breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that systems were in place to store medicines and record medicine administration. However medicines were not always administered in a manner that ensured people's safety and welfare. We saw that one person was receiving their medicine from staff who sprinkled the contents of the medicine capsule onto a jam sandwich. This was being completed against the advice recorded on the medicines instructions. The staff member who we observed administering this medicine told us that the person's GP had said it was okay to administer the medicine in this manner. However, there was no record to confirm this in the person's care records. This meant this person could not be assured that their medicine was being given in a manner that protected their safety and welfare. Therefore this was an additional breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service and their relatives told us they had no concerns about safety at the home. However, mixed views were shared about the staffing levels at the home. Only one person who used the service was able to share their views about staffing levels. They were asked if staff came to them quickly if they needed help. They replied, "Not always, sometimes they are too busy". One relative told us, "I couldn't be happier, the regular staff are good". Another relative said, "They're [The care staff] pulled inside out sometimes", and "It's very demanding up here [Upstairs lounge]".

On the day of our inspection, there were insufficient numbers of staff to meet people's needs and keep people safe. We asked two staff members why people were not supported to change their position in accordance with their care plans. Both staff members told us it was because they did not have the time to do this. One staff member said, "We do turn people, but not on time due to staffing [shortfalls]. We do try and get them [People's turning routines] done. Toileting can also be an issue". We also asked two members of staff why two people were left seated in their chairs without support to change their position or go to the toilet for periods of up to ten hours on the day of our inspection. One staff member said, "[The person who used the service] has been in the chair all day. He's not even been to the toilet. There's not been the staff". Another said, "No, [The person who used the service] hasn't been to the toilet all day. We haven't had the time". This demonstrated there were not enough suitably skilled, qualified and experienced staff deployed to be able to safeguard the health, safety and welfare of the people who used the service.

Staff we spoke with told us that one staff member had not turned up for their shift on the morning of our inspection. The deputy manager told us they had tried to cover this shift with agency staff but they had been unsuccessful in gaining cover. We saw that other staff members within the home, including; a laundry worker, the home's administrator and the deputy manager had all tried to provide cover. Despite this people's needs were still not met. This meant the systems in place to cover for staff absences were ineffective which left people at risk of harm.

Three members of care staff, the deputy manager and the principal care home manager told us that the provider had recently requested that the numbers of senior staff needed to be reduced from two to one. Staff told us and we saw that this had an impact on the care people received. For example, staff told us and we saw that people did not receive the support they required to change their positions and have their personal care needs met. One senior staff member told us, "I could do personal care when two seniors were on, but I'm unable to do so now".

The lack of sufficient numbers of staff meant that people's individual needs were not met and people's safety and welfare were compromised. Therefore this was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Inadequate

Is the service effective?

Our findings

Consent to care was not sought in line with legislation and guidance. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure that decisions are made in people's best interests when they lack sufficient capacity to be able to do this for themselves.

We saw that best interest decisions were not made in accordance with the Mental Capacity Act 2005. For example, the deputy manager told us that 20 of the 22 people had sensor mats by their beds to alert staff when people attempted to move from their beds during the night. The use of the sensor mat meant that 20 people's call bells were not operational during the night. (This was because the call bells and sensor mats could not be plugged into the system at the same time). This meant that the 20 people could not call for help by pressing their call bell during the night.

We checked the care records for three people to see if the decision to use the sensor mat and disable the call bell had been made in their best interests. We did this because care staff told us that these three people were unable to retain information. This indicated that these people may have had limited mental capacity to make decisions about their care. There was no record of a mental capacity assessment or a best interest decision in these people's care records and the deputy manager confirmed this. This meant that the legal requirements of the Act were not being followed. People could not be assured that decisions were being made in their best interests when they were unable to make decisions for themselves.

A member of care staff told us and we saw that one person's medicines were administered by hiding them in their food without their knowledge. The staff told us they did this because the person did not understand the importance of receiving their medicines. This person's care records contained no reference to their GP agreeing that this way of administering medication was necessary and in their best interests. This meant that the person could not be assured that their medicines were being administered in this manner because it was in their best interests.

The staff we spoke with were unable to tell us how they complied with the Mental Capacity Act 2005. The staff told us they had not received training in the Act. Training records showed that only one of the 35 staff members listed had received training to enable them to learn about the Mental Capacity Act 2005. This meant that the staff had not received the training they required to enable them to work in accordance with the Act.

Not following the requirements of the Mental Capacity Act 2005 meant people could not be assured that decisions were being made in their best interests when they were unable to make decisions for themselves. Therefore this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed two people who used the service request to leave the home. The care staff we spoke with told us that the two people were unable to retain information. This indicated that these people may have had limited mental capacity to make decisions about their care. These people were unable to leave the home because the units that they resided in had key coded locks in place on the doors. We saw that one of these people attempted to leave by trying to open the locked door on at least two occasions. We asked the deputy manager if the decision to prevent the two people from leaving the service had been made in their best interests via a DoLS authorisation. We were told that no DoLS had been made for either person. This meant people could not be assured that they were being prevented from leaving the home in a lawful manner. Therefore this was a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not consistently supported to eat and drink in accordance with their planned care. At lunchtime we saw there were not enough staff to support people to eat their meals. We observed a member of care staff assisting two people to eat their lunch. Both people were sitting in different locations in the upstairs lounge which meant the staff member had to repeatedly leave one person to support the other. Neither person ate their entire meal. This meant that people did not get the continual support they required in accordance with their care plans to enable them to eat their meal.

We also saw that one person had to wait 15 minutes after their meal was plated up before they received assistance to eat their meal. This was because staff were assisting other

people to eat their meals. Their meal was not kept in a heated trolley during the wait and the person was unable to tell us if their meal was a suitable temperature. This meant there was a risk they were served cold food.

The provider's failure to ensure there were enough staff to support people to eat and drink was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the care records of two people who required the amount of drinks they consumed to be monitored. Staff told us that monitoring was required because both people were at risk of dehydration. Their care records showed that the amounts of drinks they consumed were not being monitored as the staff were not calculating the overall amounts that people drank each day. As a result of this the staff had not identified that both people were regularly consuming lower amounts of drinks than what was recommended and recorded in their care plans. This meant effective systems were not in place to ensure people received support with drinking in accordance with their care plans.

We saw that one person had lost a significant amount of weight during the four months prior to our inspection. Their GP had prescribed dietary supplements to help manage the risk of malnutrition. The person's care records did not show that their supplements had been administered as prescribed. We saw that on four occasions this was because the dietary supplements were out of stock at the home. This meant that the person's risk of malnutrition was not being managed in accordance with medical advice. As a result, the care provided had failed to meet their individual needs and ensure their welfare and safety.

The provider's failure to support people to eat and drink in accordance with care plans and medical advice was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During lunchtime, we saw that meals were given to people with no consultation as to what they would like. We observed eight people during lunch time in the upstairs dining area. Three people had their plated meal placed in front of them with no explanation of what the meal was.

One of the three people did not eat their meal and they were not offered an alternative other than their pudding. Care staff told us that people had been offered choices for this meal the day before our inspection. However, the people we spoke with were unable to confirm this because of their memory problems.

There were no menus on display to remind people what the meal choices were, and the people we spoke with told us they did not know what the meal would be. One person said, "I've no idea what's for lunch". Another person said, "There is not much variety and it doesn't taste nice". No choices were offered to people at lunch time to ensure the decisions the staff told us people made the day before were still valid. This meant people were not given the opportunity to change their mind and make informed choices about the foods they ate. Therefore this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that they received regular training to enable them to provide care. The staff records confirmed that staff had received training which included moving and handling and safeguarding. However, the staff we spoke with told us they had not received training in how to manage the behaviours that people with dementia may display and the staff training records confirmed this. During the inspection we observed inconsistency with the way that staff responded to the behaviours of one person with dementia. We saw that at times the way the staff responded had a negative impact on the person's behaviour. This meant that this person received inconsistent care from the staff because they had not received the training to enable them to manage people with dementia's behaviours.

People had access to health care professionals such as; doctors, paramedics and occupational therapists. However we saw that advice from healthcare professionals was not always sought promptly. For example the provider could not show that advice had been sought in relation to the person who was walking with a broken mobility aid or the person who was receiving their medicines by having them hidden in food. This meant improvements were required to ensure advice from healthcare professionals is sought promptly when people's needs change or when risks are identified.

Requires Improvement

Is the service caring?

Our findings

We saw that people were not always offered choices about their care. People could not confirm that they were consistently given choices about the foods they ate and during our inspection we saw that people were not always given choices about the drinks they consumed. For example, we saw a member of care staff ask two people if they wanted a drink. Both people were then poured a glass of blackcurrant. No choices were offered as only blackcurrant juice was available in the room. This meant that both people were not enabled to choose the type of drink they received.

We saw that two people remained seated without being supported to have their position changed or being assisted to go to the toilet for periods of nine and a half hours and ten hours. One of the objectives in one of these people's continence care plan stated, 'To promote continence, maintain dignity and privacy and promote self-esteem'. The person was unable to tell the staff that they needed the toilet, so they depended on the staff to meet this need. Not receiving support to go to the toilet for a nine and a half hour period meant that this person's continence, dignity and self-esteem was not promoted.

The provider's failure to offer people consistent choices about their care and failure to promote people's dignity was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that when the staff had the time to interact with people this was done with kindness and care. For example, we saw one staff member gently rouse one person from a sleep by stroking their arm and talking quietly to them to wake them in a calm manner. However, we saw that the staff did not always have the time to support people with care and compassion. For example, we saw one staff member ignore one person on two occasions when they shouted, "I want to go home". This had a negative impact on the person's behaviour as they continued to shout out as their request had not been responded to. We also saw one staff member support two people to eat their lunch at the same time. This resulted in them leaving one person to support the other and vice versa. We saw that these people were not always given an explanation or apology for the disruption this caused to their meal time experience. This meant people were not consistently treated with care and compassion.

People and their relatives told us that the staff were friendly and caring. One person said, "They look after us well". A relative said, "The staff are nice and friendly". Another relative said, "The staff are caring and patient".

We saw that the staff supported people to receive treatments from visiting healthcare professionals in the privacy of their bedrooms. However a relative told us that no other rooms were available for people and their relatives to meet in other than the communal lounges or people's bedrooms. They said, "I would like another area to go to other than the lounge and bedroom". This meant that the staff promoted people's privacy, but improvements could be made to ensure people could access suitable areas to meet with their relatives.

Requires Improvement

Is the service responsive?

Our findings

People who used the service and the staff told us that staff did not have the time to encourage or enable people to engage in their preferred leisure and social based activities. One person who used the service said, "I am bored. There is nothing much to do." We asked one person what they did during the day. They replied, "Not a lot". A staff member told us how they struggled to promote activities. They said, "The activity coordinator is off sick at the moment and we just don't have the time [to promote activities]". This meant that there were insufficient numbers of staff to enable people to participate in their preferred leisure and social based activities in a consistent manner. Therefore this was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that the staff did not always have the time to meet people's individual needs in a timely manner. For example, we observed one person call out in pain on three occasions. During this observation we saw two members of staff offer the person some reassurance. However, during the observation the person was not offered pain relief or provided with practical support to help control their pain. 59 minutes after they first shouted out in pain staff supported them to receive practical support for their pain. This meant that this person's individual welfare needs were not met in a timely manner. Therefore this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that the provider was using temporary staff alongside permanent staff due to reduced staffing levels. Relatives told us and our observations showed that when permanent staff provided care it was done in accordance with people's care preferences. Staff told us they knew people well as they had worked with them over long periods of time. One relative said, "[The member of staff on duty] knows [The person who used the service] so well". However some relatives told us that they believed the agency staff did not understand people's care preferences. One relative said, "The regular [Permanent] staff are good, but I feel that agency staff [Temporary] staff don't know enough. The inconsistency isn't good for [The person who used the service]". This meant people may not have consistently received their care in accordance with their care preferences.

Some people's preferences were also recorded in their care plans which meant the information was readily available for staff to refer to. For example, we observed a staff member offer one person a chocolate bar. The staff member said, "[The person who used the service] does love their chocolate. They always have a stash hidden away here". This person's care records reflected their like of chocolate which meant the preference was recorded and available for all the staff to refer to and follow. However some people's personal preferences were not always recorded. For example, one person's care records stated that the person should be offered a snack in the evening. This person was unable to consistently express their care choices due to their communication problems, but no record of the types of snacks they liked or disliked were recorded for the staff to refer to. This meant that the information staff needed to provide consistent care in accordance with people's personal preferences was not always available. As a result of this people were at risk of receiving inconsistent or unsuitable care.

Not keeping accurate and up to date information about peoples care preferences meant that people were at risk of receiving inconsistent or unsuitable care. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with were unable to confirm that they were involved in the assessment and planning of their care. However, the relatives we spoke with told us they were involved in this process. They also told us they were kept updated about changes in their relative's needs. One relative said, "They [The staff] always ring me when things change". Another relative said, "I'm kept informed of changes". This meant that the relatives of people who used the service were involved in the assessment and planning of care and were happy with how changes about care needs were communicated.

People told us they would tell the staff or managers if they had a complaint. One relative said, "I'd have a word with the staff, but I would go into the office [To the management team] if I was unhappy". There were no complaints for us to review since out last inspection but the deputy manager demonstrated they understood the complaints process.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found that effective systems were not in place to assess and monitor the quality of care. We told the provider they needed to make improvements to ensure that the quality of care provision was regularly assessed and monitored.

Effective systems were still not in place to assess and monitor the quality of care. For example, we found that the checks needed to ensure pressure relieving cushions were safe and suitable for use were ineffective. We found two pressure cushions at the service that were contaminated with bodily fluids. We intervened to prevent care staff seating one person onto one of these cushions. We asked the deputy manager if there was a monitoring system in place to check the safety and suitability of the pressure cushions. They said, "They [care staff] disinfect them at night and wipe over the pro pad cushions. They don't unzip or check inside". This posed a risk to the health, wellbeing and dignity of the people who used the service.

The provider had failed to make improvements to the information contained in people's care records as care records continued to not always contain information that was accurate or up to date. For example the inconsistent recording of people's care preferences had not been identified and rectified by the provider which meant people were at risk of receiving inconsistent or unsuitable care.

Systems in place to identify, assess and manage risk at the service were ineffective. For example the risks associated with one person's broken mobility aid had not been identified or managed to promote their safety and the safety of other people who used the service. This meant the provider had failed to protect the health and welfare of the people who used the service.

We asked the deputy manager if they sought the views of people who used and visited the service in relation to care provision. We were told that feedback about people's individual care was sought through people's individual care review meetings. However, no formal systems were in place to gain people's feedback about wider care issues, such as; the food, environment and activity provision. The deputy manager confirmed that feedback methods, such as user meetings and satisfaction questionnaires were not in place. This meant that people were not encouraged to provide feedback about their care so that improvements could be made.

The training needs of the staff had not been identified. This meant that the staff did not receive all the training they required to provide effective care. Staff also told us they were not receiving regular supervision. The deputy manager told us they were planning to complete staff supervisions, but the recent departure of the registered manager had placed additional demands on the deputy manager's time. This meant the provider had failed to ensure staff had the knowledge and skills required to enable them to provide effective care.

The evidence above showed that the provider had continued to fail to effectively assess, monitor and improve care. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There has been no stability and continuity with the management of Samuel Hobson House since May 2013 and there is currently no registered manager in place. Staff and relatives told us that the changes in management caused instability at the service. One relative said, "We don't know what's happening with management. I can come in one day and they are there and the next day they may have left". One staff member said, "It's difficult because the management is always changing".

Staff told us that they did not always have positive interactions with the provider and the atmosphere at the service was not always positive. This meant there was a risk that staff would not approach the provider if they had concerns about the quality of care.