Roseland Lodge

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This focused inspection took place on 23 and 26 January 2018, and was unannounced. A focused inspection looks at specific concerns that we may be aware of, or which have been reported to us. At our last inspection in August 2017, we found a breach of two regulations in relation to staff recruitment and governance of the service. We rated the service as requires improvement overall. We asked the provider to complete an action plan to show what they would do and by when to improve the key question of safe and well-led to at least good, but we did not receive this. In September 2017, we contacted the provider and asked for the action plan to be sent. Again this was not received, until we contacted them in December 2017. When we did receive the action plan, it was not sufficiently detailed to assure us that breaches of regulations and areas requiring improvement were being addressed in a timely manner.

We subsequently undertook an unannounced focused inspection of Roseland Lodge on 23 and 26 January 2018. The team inspected the service against all of the five key questions we ask about services: is the service safe, effective, caring, responsive and well led.

At this inspection of 23 and 26 January 2018, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to environmental risks, staffing, governance, and recruitment. We also found a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Roseland Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Roseland Lodge accommodates eight people in one adapted building. Most were older people, some of whom were living with dementia.

There was not a registered manager in post. The provider had been managing the service since the previous registered manager left in July 2017. 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 2008 and associated Regulations about how the service is run.

People's health and safety were at risk because the provider had failed to identify where safety was being compromised in relation to environmental risks. Hot surfaces, such as radiators and heaters, had not been covered to prevent people scalding themselves were they to lean or fall against them. Fire evacuation equipment was not in place to support people out of the building in the event of an emergency and staff had not received fire training. Health and Safety Executive guidelines in relation to safety in care homes were not being followed.

Staffing levels were not sufficient to ensure people's safety at all times. Staff were not always able to be

responsive to people's needs during the day. At night only one staff member was on site, to support eight people which posed a risk to people's safety in the event of an emergency.

Appropriate recruitment checks had not been carried out on new staff, to ensure they were of good character and suitable to work with people in the service. This included obtaining references and ensuring DBS (disclosure and barring checks) were in date.

A safeguarding concern had not been reported to the relevant safeguarding authorities, which put the person involved and those visiting the service at risk. Staff were able to tell us the types of abuse they may come across in their work, however, they were not always aware of who to contact with a concern.

Some practices did not support the prevention of Infection and cross contamination.

Records made reference to people's ability to consent, and we saw staff asking people for their consent when they were supporting them. However, the management team acknowledged that they needed to increase their understanding of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards to ensure they were delivering care in line with this.

We could not be assured that suitably competent and skilled staff were deployed to ensure that people's care and treatment needs were met. There was not a training matrix in place to show when staff had undertaken training, and how often they should receive refresher training. Not all staff were receiving appropriate on-going or periodic supervision, or appraisal of their performance to ensure competence.

People received their medicines safely, however, improvements were required in relation to medicines which were taken 'as required'.

Auditing processes used to monitor the quality of the service were not robust and had not been carried out regularly. Analysis of accidents and incidents which occurred in the service was limited.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received the help they needed to see their doctor and other healthcare professionals.

Care plans were person-centred, and contained detailed information regarding people's preferences and choices. Improvement was required in relation to end of life care planning as not all records were completed.

Staff were observed to be kind and caring in their interactions with people. Relatives and visitors could visit at any time and there were no restrictions.

There was a complaints process in place, and people felt confident that they could raise any concerns with staff. However, details of how to complain were not displayed in the service.

Staff were confident to raise concerns with the provider and told us they felt listened to and supported.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of

inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Not all risks were identified in relation to people's health and safety.

Not all staff had received fire safety training and fire evacuation equipment was not in place.

Staffing levels were not sufficient. Staff recruitment procedures were not robust.

Staff were able to tell us about different forms of abuse, but weren't always sure who to report them to.

Some practices did not support the prevention of Infection and cross contamination.

Systems were in place to manage people's medicines. However, some improvements were needed.

Is the service effective?

Requires Improvement

The service was not consistently effective

Staff were not receiving all training relevant to the needs of the people they were caring for. It was not clear which staff had received training and when.

People were asked for their consent before any care, treatment or support was provided. However, staff and the management team needed to increase their knowledge around the principles of the Mental Capacity Act 2005.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Due to some of the wider failings within the service people did

not always benefit from a caring culture.

Systems for obtaining people's feedback about their care were not robust.

Staff were observed to be kind and caring in their interactions with people.

Relatives and visitors could visit at any time and there were no restrictions.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were not always able to be fully responsive to people's needs.

Care plans had been updated and were person centred, however, end of life care planning was not always fully completed.

There were systems in place to investigate and respond to complaints. However, details of how to complain were not displayed in the service.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider had not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times. Environmental risks needed addressing so people's safety was not compromised.

Quality assurance systems were not sufficiently robust and had not identified where quality and safety had been compromised. This placed people at risk of harm.

Staff were confident to raise concerns with the provider and told us they felt listened to and supported.

Roseland Lodge

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 checked 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 was prompted in part by information that had been raised to us from whistle-blowers and from other professional staff who had visited the service. The information shared with CQC indicated potential concerns about recruitment, the management of risk, care planning, scalding from hot water, and environmental risks. This inspection examined those risks.

This inspection took place on 23 and 26 January 2018 and was unannounced. The inspection team consisted of two 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. One inspector returned for a second day to complete the inspection, and announced this in advance.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We also spoke with the local authority's quality assurance and safeguarding teams who had visited the service. Following the inspection we spoke with the local fire service.

At the time of inspection there were eight people living at the service. To help us assess how people's care needs were being met we reviewed four people's care records and other information, including risk assessments and medicines records. We reviewed four staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service. During the day we spoke with four people who lived at the service, the provider, the senior carer, and two members of care staff.

Inadequate

Is the service safe?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 15 August 2017, and following concerns raised to us. At our last inspection we rated this key question as 'Requires Improvement'. At this 23 and 26 January 2018 inspection we have rated this key question as 'Inadequate'.

During this inspection, we found environmental risks that could pose a risk to people's safety or welfare. For example, we noted that all the radiators in the service were without covers, which could pose a risk of people scalding themselves were they to lean or fall against them. There were also several oil filled radiators which were extremely hot to the touch in certain rooms. We also found that some wardrobes were not secured to walls, some of which were unsteady. The provider told us they were not aware of Health and Safety Executive (HSE) guidelines relating to the above issues. They had not considered hot surfaces and the vulnerability of individuals had not been adequately assessed.

There was no fire evacuation equipment in any areas of the service, such as an evacuation sledge. In the event of an emergency this type of equipment can be used to aid the safe and prompt transfer of people. People's records did not include Personal Emergency Evacuation Plans (PEEPs). These show the support people require to evacuate the building in an emergency situation. The lack of this information meant that staff may not know how to safely support people to evacuate the building in the event of an emergency. On day two of the inspection, we did however see that the senior carer had started work on implementing PEEP's. Staff had not received training in fire safety.

There was a legionella risk assessment in place, however, this required updating as it had the registered manager's name on (who had left in July 2017). It also did not stipulate who to escalate concerns to and what action to take should issues be identified. One of the ways to reduce the risk of legionella is the effective control of water temperature. At the time of our visit we saw that hot water temperatures were being checked on a monthly basis, but no similar evidence that cold water temperatures were being checked, or that the de-scaling of shower heads was being undertaken, was available. (Although documentation on these points has subsequently been provided).

We found that laundry was being carried out in the same room where staff were cleaning commodes. This posed a risk of cross contamination.

We concluded that risks associated with people's environment were not safely managed, and the provider was not aware of guidelines relating to health and safety requirements. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection we found the provider had secured the wardrobes to the wall. They told us they had also ordered radiator covers for the whole building and was awaiting an installation date.

We had received some concerns that staffing levels were not sufficient and that sometimes people had to

wait for assistance. We asked people if staff responded quickly when they required support. One person told us, "Well it's never very long and I just have to be patient. Normally I just need one carer but if I need two it will take longer." Another said, "I use my call button and they're usually quite quick to answer."

The service was split over a ground, second, and third floor, and there was no toilet available on the ground floor. This meant that staff had to assist people into the lift, and take them up to their bedrooms to use the toilet. When this occurred it meant that one carer had to remain downstairs to monitor the welfare of other people. This meant that if two people wanted to use the toilet at the same time, one would have to wait for the other carer to return. For example, we saw one carer ask a person if they needed help, the person replied, "I'm sorry, I'm a bit out of sorts, I need to go to the toilet." The carer explained that another person had just been taken upstairs to the toilet by the other carer and when they were back they would take them. We noted that it was 15 minutes later that the person was assisted to the toilet.

There was only one carer working at the home during the night. We were concerned of the potential risks in the event of an emergency, such as a fire, and how one carer would be able to evacuate people safely. Additionally, if a person fell, or became unwell, there would be no other care staff to monitor the welfare of others in the service. We were concerned so we contacted the local fire service who visited. They instructed the provider to immediately allocate two staff members on the night shift, which we were informed they did.

We could not be assured there was sufficient staff available to ensure the safety and welfare of people at all times, and respond to people's needs in a timely manner.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were able to identify different types of abuse they may come across in their work, but weren't always sure where to report concerns to outside of the service. One staff member said, "I would report any concerns to the senior or the safeguarding team, but I'm not sure of their contact details." Additionally, there had been an incident which had occurred in the service which we felt should have been referred to the safeguarding team but had not been. This put the person and others visiting the service at risk. We asked the senior carer and provider to make the referral to the local safeguarding team, which they did whilst we were present. The senior staff member was not aware of the contact number for the local safeguarding team, which demonstrates that further improvements are needed to ensure all staff are aware of reporting procedures.

The previous inspection on 15 August 2017 found that the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not always been subject to appropriate checks before commencing employment, such as obtaining references, and Disclosure and Barring checks, which informs the employer if the staff member has any criminal convictions, or have been banned from working in the care sector. We found two staff did not have DBS checks in place.

At this inspection on 23 and 26 January 2018 we found continued concerns that recruitment procedures were not safe or robust. A new staff member had been employed recently, and only one verbal reference from their previous employer had been received, the details of which were not recorded on their recruitment records. The second reference had not yet been obtained from their previous employer, and the staff member was working in the service. In another case a staff members DBS check had been copied, but the date was not visible. We therefore could not be assured that there were adequate checks in place to ensure

staff were suitable to work in the service.

This constituted a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in the service told us they felt safe. One person said, "It's very good here, they look after me well and I feel safe." Another said, "I do [feel safe] I came here because I was having falls at home, I've not had a fall since I've been here."

Staff administering medicines had received on-line training, but not practical face to face training. The senior carer told us that they were planning to request practical training from the local pharmacy team who were visiting the following week.

We checked the systems in place for managing people's medicines. Medicine administration records (MAR) were consistently signed to show when people had been given their medicines. Dates were written on opened liquid and topical applications to ensure they did not expire and remained safe to use.

Where people were prescribed 'as and when' (PRN) medicines, appropriate guidance was not in place to instruct staff on the intended purpose of these medicines and when they should be administered. This presented a risk that they could be used inappropriately. The senior carer told us that they had expected a visit from the local pharmacy support team but this was cancelled. However they were returning to the service the following week when they would put these in place. Supporting information also needed to be made available, such as how people preferred to take their medicines, so staff could refer to this.

At the time of our visit, we found no evidence that daily temperatures had been taken and recorded where the medicine trolley was stored. This meant the effectiveness of medicines could have been compromised as there was no system in place to ensure that medicines were being stored at safe recommended temperatures. The senior carer told us they would start these immediately, and were also planning to move the medicines trolley to a dedicated room (although documentation has been provided by the provider subsequently, which records temperature readings).

Homely remedies were in place for some people. Homely remedies commonly refers to a range of frequently used medicines which people are able to buy to treat minor illnesses. Examples include painkillers such as paracetamol. We saw that where these were in place, the GP had been consulted and signed to agree the person was able to take these.

There were no people taking controlled drugs currently in the service, but we saw there were suitable storage facilities for these types of drugs. The senior staff member was able to explain the requirements of controlled drugs, such as two staff administering and signing for the medicines. There were storage facilities for temperature sensitive medicines, and we noted that this was set at the correct temperature.

We found that equipment, such as hoists had been serviced and checked so they were fit for purpose and safe to use.

The service needed to develop their practice to ensure that lessons were learned and improvements made when things had gone wrong. For example, following our previous inspection, there was still limited analysis of accidents and near misses. Additionally, staff were still not being recruited safely. This did not give us confidence that the provider was learning from and developing systems and processes which supported improvement.

At our last inspection of 15 August 2017, we found that risks to people's safety had not always been managed safely, and staff did not have full guidance on how to mitigate risks relating to pressure area care, nutrition and falls. At this inspection 23 and 26 January 2018 we found that this had improved. The senior carer had been allocated the responsibility of updating all risk assessments, and we found risks were now much clearer, and included moving and handling, eating and drinking, bed rails, pressure care, falls, and health conditions such as diabetes. There were two people's records still in the process of being updated, but staff and the senior carer were fully aware of the risks and were able to tell us how these risks were being managed.

The service had a staff member who was the infection control lead. They attended local meetings to keep up to date with best practice, and raise any questions they may have. We found that the accommodation was clean and had a fresh atmosphere. Cleaning schedules were in place in people's rooms, which included checks on commodes, toilets, tables, and linen. Staff had access to personal protective equipment, for example, gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection 15 August 2017, we rated this key question as 'Good'. During this 23 and 26 January 2018 inspection, we have rated this key question as 'Requires Improvement'.

At the 15 August 2017 inspection, the provider informed us that they were going to invest in an external training package to ensure staff received relevant and up to date training. Although they had taken steps to do this, the training package had not met their needs. They subsequently registered with an accredited e-learning provider for health and social care providers, so they could access online training.

Prior to our inspection on 23 and 26 January 2018 inspection, we had received concerns that staff had not received training within the service. We contacted the provider in December 2017, and requested training records. For each area of training a date had been allocated for the training to be completed by, but there had been no consideration of when each staff member had last completed their training, or at what interval refresher training should be undertaken. It was also not clear how the training was to be delivered; practical or theory. For example, moving and handling training in line with best practice guidance, should be delivered as a practical session so staff can practice using equipment such as hoists. The senior carer told us that they were observing staff using manual handing equipment to ensure they were competent, however, they were not qualified to assess staff competency.

Not all staff had received relevant training, such as end of life care, pressure area care, and dementia care. Staff files did not always contain information on when training was last completed, and not all staff members had training certificates on file. Therefore the provider could not be sure that staff were up to date in their knowledge. This meant the provider was not ensuring that staff were gaining the necessary skills to meet the needs of the people they cared for.

The services Statement of Purpose, stated that staff will receive supervision, "Regularly and carefully." However, staff working in the service were not supervised adequately to ensure that their competency and application of their learning was effective. Not all staff were receiving appropriate on-going or periodic supervision, or appraisal of their performance to ensure competence was maintained. We noted that only two staff supervisions had taken place in October 2017.

Staff should receive appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

All of the above constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they received a good induction, and were provided with 'shadow shifts' to build their confidence and get to know people. One staff member said, "My induction was good, I was asked if I felt okay to work alone, I did as I have always worked in care. I got to know the residents well first and shadowed staff."

The Mental Capacity Act 2005 (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 they lack mental capacity to take particular decisions, any decision 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 MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

During our inspection we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. One person told us, "Normally I'm able to do what I want when I want. I get up and go to bed when I want. If my [relative] comes to visit, we go out for lunch which I enjoy." We observed staff seeking consent to help people with their needs. However, we could not be confident that all staff had received training in MCA as only one staff member had a certificate on file which demonstrated this and there was no training matrix in place. One staff member said, "I haven't yet done my MCA training, but it's about when people haven't got capacity to make a decision. If they refuse [my help] I encourage them but you can't force people."

People's records made reference to their capacity to consent to care, and if there were legal representatives in place. Where people were not able to communicate well, there was guidance for staff on how to communicate in other ways, for example, showing people choices so they can make a decision. Where people had mental capacity but chose to make unwise decisions about their health and care, this was also well documented. One person told us, "I am diabetic. I just want to eat what I want, so I do. I know what I'm doing and no-one lives forever, I think that's up to me."

The senior carer told us that they were trying to learn more about the MCA as there were gaps in their knowledge. However, they had made an application for one DoLS appropriately. We saw that the senior carer had promptly carried out a mental capacity assessment, discussed the DoLS with the person's legal representative, and made the application. Whilst this was a positive step, the service needed to ensure that all staff and management were fully knowledgeable in this area, to ensure people were not unlawfully being deprived of their liberty.

People's needs and choices had been considered and assessed. Care plans were very detailed and person-centred. They demonstrated that when necessary, professionals had been brought in for advice and guidance.

People told us they enjoyed the food and had plenty to drink throughout the day. One person said, "The food's alright here. It's quite tasty, it's hot and I get enough." Another told us after having eaten their meal, "That was very nice, I enjoyed that." A third said, "I particularly like the food; it's very nice, just how I like it." We observed drinks being offered regularly, and for those people in their rooms, we saw hot drinks and juice were within their reach.

We observed the lunchtime meal. The dining room was small, clean and well decorated. There were three tables laid with table cloths, condiments, place mats and cutlery, together with glass tumblers. There was a black board on one wall showing the meal options for lunch; a choice of two meals and two puddings. People were offered a choice of squash or water to drink. Staff served the food to people, and explained to them what was on the plate. The food looked and smelled appetising.

Where people were nutritionally at risk we saw that food and fluid monitoring records were in place. Staff knew which people required help to eat, such as cutting up their food, or serving them softer food.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received the help they needed to see their doctor and other healthcare professionals such as community nurses, physiotherapists and occupational therapists. There were also letters and information on people's files from other professionals and hospital visits. One person told us, "I have had quite a nasty cough and cold, I really wasn't feeling well. They [staff] called the doctor out and she's put me on anti-biotics. If you need the doctor they'll call and arrange a visit."

The provider had given some thought to the suitability of the premises for the benefit of people living with dementia. For example, people's bedrooms were personalised and well decorated, and each bedroom door was painted a different colour which helped people to recognise their own bedroom. However, some further improvements could be made. Although the home was small there was limited way finding signage, and the stair and landing carpets had a small, complicated pattern which might prove confusing to someone living with dementia.

We recommend that the service explores current guidance from a reputable source (such as the Social Care Institute for Excellence) to further improve the design and decoration of the service, and consider best practice for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

During our last inspection on 15 August 2017, we rated this key question as 'Good'. At this inspection on 23 and 26 January 2018 we have rated caring as 'Requires Improvement'. Due to some of the wider failings in the service, people living at the home did not always benefit from a caring culture. The concerns we raised during our last inspection in August 2017 had not been adequately addressed by the provider to ensure people were safe. For example, ensuring staff were recruited safely. This put people at potential risk of harm, and did not demonstrate a caring approach.

During this inspection, although people told us that individual staff were kind and caring, people's views were not routinely sought to ensure they were happy with the care and treatment they received. The senior carer told us that resident meetings were not routinely taking place in the service at present, but they had planned to start these again.

The service was small, and as such people and staff knew each other well. We observed that care staff were kind and considerate with people. We observed one person ask for assistance to use the toilet. The staff member helped them up and proceeded to walk very slowly towards the door. The person suddenly became distressed whilst walking, and we saw the staff member constantly reassuring them. They distracted the person by asking them to recite a poem, which the person did, and this calmed them. They went upstairs in the lift and returned 25 minutes later. The person looked very smartly dressed, their hair was brushed and they appeared to be much more settled. Later in the day, the staff member told us that they thought the person was, "Amazing", and, "[Person] can't remember what they had for breakfast, but if you ask them to sing, they can remember all the words."

People's care plans had not always been signed to demonstrate people's consent to their care, however, we were confident people had been involved in developing their care plans due to the detailed information and preferences noted. One person told us, "They [staff] are very caring here; I think they do a good job of looking after me and we get on." We observed that communication methods were considered to ensure people could indicate their views. At lunchtime people chose from the menu what they wanted, but one person was shown the choices plated up. A staff member said, "That's the best way for [person] to see what food is on offer, so we always bring it out to show them."

People's privacy and dignity was considered, as well as their independence. One person told us, "At the moment I have to have a wash rather than a shower or bath, I only have to ask and they'll give me a wash and I think they're very respectful about it." Care plans reflected people's ability to still make choices for themselves, and areas of care they could still attend to independently. One care plan said, "Encourage [person] to try and eat without assistance as they still have control of their hands", and," Always offer [person] the choice of what to wear".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 15 August 2017, we rated this key question as 'Good'. At this 23 and 26 January 2018 inspection we have rated this key question as 'Requires Improvement', as we found that staff were not always able to be fully responsive to people's needs.

The service needed to develop their practice in supporting people in relation to their end of life care. Planning ahead for when people may no longer be able to communicate their views regarding end of life wishes is sometimes called 'advance care planning'. This involves thinking and talking about how people choose to be cared for in the final months of their life. Although we found that advance care plans were in place, some of which included important information, not all plans were completed fully. Additionally, staff had not received end of life care training. The senior carer told us that they planned to ensure all staff were trained in the subject and intended to source a suitable course as soon as possible.

There was a staff member allocated to providing activities, but we were also told that care staff supported people to take part in activities such as painting their nails or just chatting. During the day, seven out of the eight people using the service were sitting in the lounge. Sometimes they slept, two were reading at intervals during the day and all the time the television was on but the volume was not up loud enough to hear it. The senior carer told us they planned to implement a structured activities programme so people could choose what they took part in.

Care staff came in and out the lounge frequently. They had short conversations with people, checking if they needed anything. Of the people we spoke with nobody expressed a concern that they were bored. However, we spoke with the provider about ensuring that people were asked what their preferences were in relation to meaningful stimulation, and that this was recorded in their care plans to ensure individual needs were being met. One person told us, "I like to watch television and sometimes I read, though not papers these days because there's so much rubbish written. I like to pass the time talking with the other residents; it's quite sociable here really." The senior carer told us that they were planning to implement a structured activity schedule and display this in the service.

During our last inspection on 15 August 2017, we found that care plans did not always guide or reflect the care that was given. At this inspection on 23 and 26 January 2018 we found improvements had been made. Care plans were person-centred, and contained detailed information regarding people's preferences in relation to what time they liked to get up and go to bed, how they like their tea served, and if they liked their door left open at night. Care plans included information on mobility, personal care, night routines, and any associated risks. One care plan contained information on their social history and activity preferences, but this was not consistent across all care plans. The senior carer told us that they were planning to improve this. Staff told us that they had time to read the care plans, but also knew people's preferences well.

There was a complaints policy in the service, however this was not displayed so people, and those visiting, knew how to raise a complaint. The service had received one comment from a relative regarding the cleanliness of a carpet. The senior carer told us that they had immediately arranged to have the carpet

cleaned. One person told us, "I don't complain as I have nothing to complain about, but I would if I had to. I would speak to any of the staff."

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 15 August 2017, we rated this key question as 'Requires Improvement'. At this inspection on 23 and 26 January 2018 we rated this key question as 'Inadequate'.

During the 15 August 2017 inspection we found that there was not a registered manager in post as they had left three weeks before the inspection. The service informed us that the registered manager would no longer be managing the service. We found that the service had not been consistently well-led, as we found there had been little oversight of accidents and incidents in the service and no auditing of care records, including assessment of risk. This meant they were in breach of regulation 17. We asked the provider to send us an action plan covering the areas identified as requiring improvement, but we did not receive this. In September 2017, we contacted the provider and asked for the action plan to be sent. Again this was not received, until we contacted them in December 2017. When we did receive the action plan, it was not sufficiently detailed to assure us that breaches of regulations and areas requiring improvement were being addressed in a timely manner.

At this inspection on 23 and 26 January 2018, we found that there was no registered manager in post, and that the provider had continued to manage the service. They had taken steps to recruit a new registered manager, but they had not found a suitable candidate. The provider did not have a background in care, but had been supported by a senior member of staff. The provider told us they were trying to increase their own knowledge around the care sector, and had been reading information relating to infection control and health and social care.

Auditing processes were still not robust, for example at our last inspection we found there was little analysis of accidents and incidents. At this inspection, details of incidents were being logged, but we found there was limited analysis of accidents and incidents. Data relating to falls needs to be analysed in detail to identify any trends, such as the time of day a person is most likely to fall, and this was not being completed. Other audits such as infection control had not been carried out since November 2017. Medicine audits were being carried out but contained little information on quality of recording, and was more of a 'tick box' exercise. Staff recruitment was still not being safely managed, which put people at potential risk of harm.

There was a maintenance audit in place which was had been completed by the provider in December 2017. This included checking room call bells, emergency lighting, fire extinguishers and that electrical appliances had been tested. There was an action point made to start a temperature log of water, which we saw was in place. However, the provider had failed to identify environmental risks, such as a lack of fire safety equipment, and people being exposed to hot surfaces. They were not aware of the Health and Safety Executive guidelines in relation to care homes.

There was a lack of quality assurance systems to continually monitor the service provided to ensure people received safe and effective care at all times. This meant we could not be assured that the oversight of the providers systems and processes was consistently effective at identifying issues and driving necessary improvement.

This demonstrates a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had informed us of two deaths which had occurred in the service in 2017. Notifications about deaths must be sent to us without delay. We found two deaths had not been reported to us for between seven and 15 days.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

The senior carer had been pro-active in making improvements to people's care records and we could see these were being reviewed regularly. Risk assessments were also being completed and were more detailed.

Staff meetings had been held in the service on a monthly basis by the provider since September 2017, where they explained to staff that they would be managing the service, and wanted to sustain the 'family environment' in the service. Other relevant issues were discussed such as people's moving and handling needs, and most effective communication methods. We also saw that the provider had thanked staff for their work and for covering shifts. Staff told us they felt supported. One staff member said, "I do feel over worked sometimes, but appreciated. [Senior carer] is very good. They listen." Another said, "I think the service is well run, it's like a family here." However, in relation to informing people living in the service of the changes to the management of the service, we weren't assured that they had been informed in the same way. One person told us, "We only really found out bit by bit and by talking to the carers. That was a bit disappointing."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The service did not notify CQC without delay about deaths which had occurred in the service. 16 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service and others were not protected against the risks associated with unsafe premises because the registered provider had failed to recognise this. 12 (1) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not adequate to monitor and improve the service provided. They did not identify where quality and safety were being compromised. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Not all recruitment checks had been completed to ensure staff were suitable for the role.

19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to meet people's needs and keep them safe at all times. Staff were not trained in all areas relevant to their role. It was not always clear what training staff had undertaken. Staff were not receiving periodic supervision in their role to ensure competence was maintained. 18 (1) (2) (a)