Anchor Trust

Linwood

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

Overall summary

Linwood is a care home that provides personal care for up to 67 people. Some of the people at Linwood are living with dementia. The home is set across three floors and has a spacious back garden.

At the time of our inspection 58 people were living at Linwood. This inspection took place on 11 June 2015 and was unannounced.

The home is run by a registered manager, who was present on the day of the inspection. 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 overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

Summary of findings

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

There was an insufficient number of qualified staff deployed to meet the needs of all people who required care. Risk assessments were in place, however people were placed at risk of harm as appropriate guidance and best practice was not always followed.

Staff understood what to look for when they suspected abuse, they did not know how to report it outside of the company. We have made a recommendation about staff reporting concerns about abuse to the local authority.

Staff did not have a clear understanding of their responsibilities regarding the Mental Capacity Act or Deprivation of Liberty Safeguards. Where people lacked capacity they were not fully protected and best practices were not being followed in accordance with the Mental Capacity Act.

Where restrictions on people were in place to deprive them of their liberty, there was confusion as to the progress of each application, in line with the legal requirements to make sure this was done in the person's best interest. The registered manager had submitted Deprivation of Liberty Safeguards (DoLS) applications to comply with their responsibilities. We have made a recommendation that arrangements and best practices are followed in accordance with current legislation.

The environment was not conducive for people living with dementia or sensory impairment, as the décor was of the same colour and no distinction between sections of the home, it was difficult to assist people's orientation as they may find it difficult to find their way around without there being some adaptation to the environment. We have made a recommendation that the provider to make the environment used by people who live with dementia more 'dementia friendly'.

We noted that there were inconsistencies in the care people received. We observed some incidences of improper care. There were also inconsistencies about how people were involved in making decisions about their cafe and treatment.

We observed good and poor examples of how staff knew and responded to people's needs. Care was not always based on individual needs, care and treatment. People had access to activities, however there were mixed feelings about the activities provided. People were protected from social isolation through systems the service had in place. We found there was a range of activities available within the service and the local community, however not all of the activities were age appropriate or stimulated people. We have made a recommendation that the provider reviews activities in line with people's interests and hobbies.

The management and leadership of the home were ineffective. We were concerned about the lack of understanding or knowledge of people living at the home by the management team. They were unable to accurately recall the number of people living in the home, for whom DoLS applications had been made or that a person was unwell.

There were quality assurance systems in place, to review and monitor the quality of service provided, however they were not robust or effective at identifying and correcting poor care or practices. This meant that whilst there were arrangements in place to manage standards, people were not fully protected against the risks as there was no systematic approach to managing them.

People told us that they felt safe at Linwood. People told us, "We are looked after very safely here." Staff had a good understanding about the signs of abuse, however apart from reporting the incident to their manager; they did not know what to do. There were systems and processes in place to protect people from abuse.

Recruitment practices were safe and relevant checks had been completed before staff commenced work. Medicines were managed safely. Any changes to people's medicines were prescribed by the person's GP.

People's preferences, likes and dislikes had been taken into consideration and support was provided in

Summary of findings

accordance with people's wishes. People's relatives and friends were able to visit. Staff told us they always made sure they respected people's privacy and dignity before personal care tasks were performed.

People had enough to eat and drink throughout the day and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and healthcare professional were involved in the regular monitoring of people's health. The service worked effectively with health care professionals and referred people for treatment when necessary.

People told us if they had any issues they would speak to the manager. People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was an insufficient number of qualified staff deployed to meet the needs of all people who required care.

Staff knew what to look for if they suspected abuse, however they did not know who to report it to outside of the company.

People were placed at risk as appropriate guidance and best practice was not always followed, and resulted in a person being injured.

There were appropriate checks undertaken to help ensure suitable staff worked at the home with adults at risk.

Staff followed good medicines management procedures.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not have a clear understanding of Deprivation of Liberty Safeguards (DoLS) or the Mental Capacity Act (MCA) or their responsibilities in respect of this. Mental capacity assessments had not been fully completed in accordance with current legislation.

The environment was not conducive to people living with dementia.

Staff were trained and supported to deliver care.

People were provided with enough food and drink throughout the day and there were arrangements in place to identify and support people who were nutritionally at risk.

Staff provided care, treatment and support which promoted well-being; however there were inconsistencies with the level of care and support provided.

Staff ensured people had access to external healthcare professionals when they needed it. People's changing health needs were monitored by staff.

Is the service caring?

Requires improvement

The service was not always caring.

People's privacy were respected and promoted. Staff involved and treated with compassion, kindness and dignity. However, there were occasions were people's dignity and respect was not upheld.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

There was inconsistencies to the response to people's care needs.

People were supported to participate in a range of activities; however there was a lack of individualised stimulation.

People and their relatives were not always involved in developing care plans, changes to people's needs were not always reflected and acted on by staff.

People were able to express their views and were given information how to raise their concerns or make a complaint.

Is the service well-led?

Inadequate 

The service was not well-led.

There were inconsistencies about how effective the management and leadership was.

People and relatives told us the registered manager was very supportive and visible in the home. However the registered manager and care manager did not know people or their individual needs.

Records were not always kept up to date or contain relevant information for staff.

We noted that the Commission had not received notifications from the provider as required.

Quality assurance checks were not robust or effective to ensure that the home was safe for people.

Linwood

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.

This inspection took place on 11 June 2015 and was unannounced. The inspection team consisted of three inspectors and an expert by experience who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

On this occasion we had not asked the provider to complete 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. This was because we were responding to some concerns we had received. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

As part of our inspection we spoke with 14 people, 11 staff, two relatives, the registered manager, care manager and district manager. We spent time in communal areas observing the interaction between staff and people and watched how people were being cared for by staff.

We reviewed a variety of documents which included eight people's care plans, five staff files, and some policies and procedures in relation to the quality of the service provided.

We last carried out an inspection to Linwood in May 2014 and found no concerns.

Inadequate

Is the service safe?

Our findings

People told us that they didn't feel there were enough staff. One person told us, "At times I feel they are little bit short staffed. I can look after myself but other people need help from staff." Another told us, "I don't think there are enough staff. There is quite a turnover." A third told us, "There are plenty of staff sometimes, at other times not so many, usually at weekends." Staff told us, "I think there is enough staff here." The only problem occurs when there is sickness and annual leave to cover." They felt that the team leaders are not always "Hands on."

There were not always enough staff effectively deployed to meet people's needs. The service was divided into six units over three floors. On the ground floor there were 17 people being cared for by three staff, on the first floor there were 23 people cared for by four staff and the top floor there were 18 people cared for by four staff. One team leader who was supporting staff over three floors which included administering medicines and providing staff with guidance and instruction when needed. The other team leaders were completing paperwork and had training which meant they were not available to support staff. We were told by the registered manager that there should be a minimum of 13 staff which should include two team leaders and that staffing levels were determined based on people's assessed needs.

We reviewed the staffing rotas over a four week period; we found that on eight separate days staffing allocation for both early and late duty shifts were between 10 and 12 members of staff per shift which was below the minimum amount of staff required. There was 13 additional occasions were staffing duties for either the early or late shift was under the minimum staffing levels of 13. This meant the service on these days was operating below the minimum staffing levels the registered manager had determined as being needed to support people safely. We saw how the deployment of staff affected how people's needs were met. For example, on the ground floor one person had to repeatedly ask staff for a cup of tea but this was not provided for a considerable length of time. On the first floor one person was unwell in the communal area and needed two staff to help them return to their room. Staff could not find anyone else to help them move this person safely; they asked an inspector to intervene to summon help to ensure they could return the person to their room.

Risk assessments were discussed with the involvement of relatives and social or health care professionals. Staff were knowledgeable about people's needs, and what techniques to use to when people were distressed or at risk of harm. There were risk assessments in place and a plan of action for staff to manage the risks; however where people displayed behaviour that challenged staff and required two members of staff to provide support, this was not always followed. As these instructions and actions were not followed it resulted in a resident being injured. This meant that people were placed at risk of harm as appropriate guidance and best practice was not always followed.

Where people were at risk of developing pressure sores there was a plan in place to reduce this risk which was followed. For example by using pressure mattresses or pressure cushions.

As there were not enough staff deployed to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a staff recruitment and selection policy in place. Staff confirmed they submitted an application form providing full employment history, information about previous training and qualifications, two references and proof of identity. We saw that the provider had obtained and verified information provided and completed criminal record checks before staff started work.

People told us the staff were very good and they felt safe with them. One person told us, "I feel very safe here." Staff understood what to look for when they suspected abuse but they did not always know who to report it appropriately outside of the company. There was a copy of the most recent local authority safeguarding policy and company policy on safeguarding adults which provided staff with guidance about what to do in the event of suspected abuse. Staff told us that they had received safeguarding adults training within the last year. We confirmed this when we looked at the staff training programme. Staff told us, "You need to make sure people are safe. Protect them from abuse like physical, mental, financial and sexual." Another member of staff told us, "We are trained in safeguarding, If I witnessed safeguarding issues, I would discuss it with colleagues first and then go to the management." All staff stated that they would report the incident to the manager.

Inadequate

Is the service safe?

We recommend that staff are made aware of when to report any concerns about suspected abuse to the local authority.

Fire safety arrangements and risk assessments for the environment were in place to keep people safe. There was a business contingency plan in place; staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts and flooding. The provider had identified alternative locations which would be used if the home was unable to be used and would help minimise the impact to people if emergencies took place.

Comments from people about their medicines included, "If I complain about pain, they give me painkillers", "I get my medication as I should", "I get my medication when I expect it" and "The staff stop and check I take it." We observed staff asking a person if they were in any pain and would they like something for it. Only staff who had attended training in the safe management of medicines were authorised to administer them. Staff attended regular refresher training in this area and after completing this training, managers observed staff administering medicines to assess their competency before they were authorised to do this without supervision. When staff administered medicines to people, they explained the medicine to them and why they needed to take it. Staff waited patiently until the person had taken the medicine. Staff knew the importance of giving medicines on time and the reasons why this was important to reduce the risk of side effects.

A medicines profile had been completed for each person, and any allergies to medicines recorded so that staff would know which medicines people should receive. The medicines administration records (MAR) were accurate and contained no gaps or errors. A photograph of the each person to ensure that they were giving the medicine to the correct person was present. There was guidance for people who are on PRN [as needed] medicines. Where it indicated the person could have one or two tablets staff recorded how many had been given. Medicines were stored securely. All medicines coming into the home were recorded and medicines returned for disposal were recorded in a register. Medicines were checked at each handover and these checks were recorded.

Requires improvement

Is the service effective?

Our findings

Staff did not have a clear understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. People whenever possible should be enabled to make decisions themselves and where this is not possible any decisions made on their behalf are made in their best interests. Staff told us**,** "In the first instance you must assume someone had capacity. You look at the guidelines, look at what's in their best interest (if they can't consent and don't have capacity). You ask people what they want." We reviewed the provider's records and saw that staff had received the training in the MCA but this had not been embedded into practice.

We saw staff obtained consent before carrying out any tasks for the person, for example in relation to care being offered. Staff had a clear understanding for the need to obtain consent for day to day decisions however were unsure what to do where people lacked capacity about important decisions. Where important decisions needed to be made there had not been a mental capacity assessment completed to see if they could make the decision for themselves. This meant that where people lacked capacity they were not fully protected and best practices were not being followed in accordance with the MCA.

Failure to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The registered manager did not know how many people required a DoLS application but said that five had been applied for although they were unclear what stage this process was at.

Most people were able to move freely around the house; however some told us that they felt their movements were restricted. Some stated that they had been told by staff they could not leave the building unaccompanied. When we spoke to the registered manager they told us that people were able to go out whenever they wanted to and we did not see people being stopped by staff or their movements restricted.

We recommend that the service reviews its DoLS applications to ensure that people are protected from having their freedom restricted in accordance with legislation.

It was not easy for people living with dementia or who had impaired sight to find their rooms or their way around the service as all areas looked the same. Sections of the service were not easily identifiable; walls and doors were painted the same colour. Although there were signs on the doors describing rooms there were no visual aids to help people. People who were living with dementia may need help with finding and recognising their bedrooms. An environment decorated in contrasting colours may help people's orientation and support their independence.

We saw that only one person had a photograph outside their room so they were able to identify it. There were specific areas in the home where reminiscing objects or pictures could be found to help but these were not being used as they were not in a place that was recognisable or of interest to people. The management team told us that they recognised that more was needed to improve the service for people with dementia and they told us they were discussing how they could do this with the local authority.

We recommend that the provider researches and implements relevant guidance on how to make environments used by people who live with dementia more 'dementia friendly'.

People felt that staff were competent, comments included, "They seem to be good at what they do, but will ask the team leader for help", "They seem very well qualified here." and "Most staff here are very good at talking to you."

Staff had the appropriate and up to date guidance in relation to their role. Comments from staff included, "Training is regular and on going. It is good, lots of it" and "You can ask for training and they would consider it" and "I've never been turned down for training." The registered

Is the service effective?

manager ensured staff had the skills and experience which were necessary to carry out their responsibilities. New staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. The registered manager confirmed that they did not use agency staff, so additional duties were covered by bank staff that were familiar to the home and were knowledgeable about people and understood their individual needs.

Staff had received training in areas relevant to their roles. Staff told us they received dementia training. They were able to tell us the different types of dementia and had a good understanding of the needs of people living with dementia. They said training was better than before." Training covered areas such as: medicines, safeguarding, moving and handling, fire awareness, food hygiene, health and safety, infection control, dementia awareness, Mental Capacity Act (MCA) 2005, and Deprivation of Liberty Safeguards (DoLS). There were qualified, skilled and experienced staff to meet people's needs. During our observations, we saw staff assisted people to stand up from a chair using their own walking frame. Conversations with staff and further observation of transfer techniques confirmed that staff had received training and that they had sufficient knowledge to enable them to carry out this task safely and effectively.

Staff told us they had regular meetings with their line manager to discuss their work and performance. A member of staff said, "Yes I have it (supervision) once a month and I talk about issues and any concerns that I have and I had an appraisal three months ago." The registered manager confirmed that monthly supervision and annual appraisals took place with staff to discuss issues and development needs. We reviewed the provider's records which reflected what staff had told us. This meant that staff had received appropriate support that promoted their development.

People had mixed views about the quality of the food and said that on occasions the menu was changed at short notice without telling people. One person told us, "The quality of the food has deteriorated", another told us, "The food's not bad, and it doesn't suit you all the time" whilst a third told us," If you don't like the menu, the chef will do something else." One relative told us, **"**Not sure the food is adequate, supper is very early and you have to wait again until breakfast. It does look nicely presented."

Lunchtime was observed as a social occasion. People were able to choose who they sat with and some people enjoyed their lunch together outside on the balcony, laughing and joking with each other. People were involved in the choice of menu for breakfast, lunch and tea. We saw staff offer plates with different meals to people to allow them to see what was available before making a choice. Staff assisted people during mealtimes to ensure that people were supported appropriately to eat. There was a choice of nutritious food and drink available to people throughout the day; an alternative option was available if people did not like what was on offer.

Where people needed to have their food and fluid monitored and recorded this was being done appropriately by staff. The chef had records of people's individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. Staff told us, "We record the resident's food and fluid intake for lunch after the meal." Staff confirmed that a dietician was involved with people who had special dietary requirements. For example, the chef would discuss the menu with dietician to ensure that people were receiving the necessary nutritional requirements.

People told us "We are given drinks through the day", "There are fluids here and the water is changed daily." We observed people being offered drinks, smoothies and ice creams throughout the day due to the hot weather. Staff were clear about the need to keep people hydrated. People who were at risk of malnutrition told us they were weighed regularly so that staff could be sure they were getting enough to eat.

People had access to healthcare professionals such as GP, district nurse, dietician, and speech and language therapist and other health and social care professionals. One person told us, "The doctor is next door. They will make appointments if you are unwell." Another person told us, "They take us to hospital for tests by ambulance and a carer goes with you." We saw from care records that any changes to people's needs, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in their

Requires improvement

Is the service effective?

care records and staff were told what actions they should take to keep people well. This meant staff were given clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

Requires improvement

Is the service caring?

Our findings

We found there were inconsistencies in the care that people received. During our observations, we saw examples of good and poor care; staff were very busy which had an impact on the support provided. We saw staff raised their voice to a person who was making a noise with their cutlery whilst waiting for their lunch to arrive. The person stopped when requested by staff and 10 minutes later started to make the same noise, this time a different member of staff approached them and tapped them on the head and said "Please stop it X."

Staff interacted with people throughout the day, for example, when providing support to assist with people's mobility, they checked throughout the task that the person was happy with what was being done. Some staff spoke to people in a respectful and friendly manner, others did not. In some of the lounges the television was on and the volume was very loud but no-one was watching it, in some places the music from the activity room was playing as well and we observed that some people were becoming quite irritated by the noise.

Failure to provide care and treatment in a way that ensures people's dignity and respect is a breach Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us, "Staff respect me and protect my dignity" and added "I've no problem with being given respect and dignity. They close my door when attending to me." Staff approached people with kindness and compassion. We saw that some staff treated people with dignity and respect and called people by their preferred names. All personal care was provided in private. Staff told us, "I am happy with what I do, I love the people here, and all I want for them is the best." We saw staff assisted people to stand up from a chair using their own walking frame; this was carried out sensitively and skilfully. When the person's trousers started to slip down staff acted swiftly to protect their dignity. During the process staff constantly reassured them and told them what was happening.

There were mixed comments about how people were involved in making decisions about their care and treatment. One person told us, "I am aware I have a care plan but they don't talk to me about changes." Another person told us, "My relatives are contacted if there has been a problem." Relatives and health and social care professionals were involved in individual's care planning. There were regular meetings with people about how the service was run however these had been reduced from four per year to three. In relation to mealtimes people were not involved in the development of the menu or when meals were provided and that, on occasions, people went to bed feeling hungry. People told us that they "Adjusted to the times" and now went to bed "Early."

Failure to provide care and treatment in a way that is person centred is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff gently coaxed a person to join in an activity which they subsequently really enjoyed. We saw some staff displayed a caring and thoughtful attitude towards people throughout the whole inspection. Comments from people about the care included "On the whole we are very well looked after here", "The care is quite good" "Most of the time the staff are good. They have good days and bad days."

Relatives and friends were encouraged to visit and maintain relationships with people. A relative told us, "I think the care is excellent. The carers are helpful and kind, they enjoy the job. A carer waited in the hospital with me when mum was admitted." People confirmed that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres. We also saw that religious services were held in the service and these were open to those who wished to attend.

Staff knew about the people they supported. They were able to talk about people, their likes, dislikes and interests and the care and support they needed. We saw information in care records that highlighted people's personal preferences, so that staff would know what people needed from them. Staff told us, "We do build life histories of new residents and each resident has a likes and dislikes section in their care plan called - social history." However we noted that most of people's care plan did not contain a life history about the person's past interests or life. This meant that there was not a full account of an individual's life to help staff provide person centred care.

People were able to make choices about when to get up in the morning, what to wear and activities they would like to

Requires improvement

Is the service caring?

participate in, so they could maintain their independence. One person told us, “They will give me a bath when I want it” and “They (staff) are all pretty good with me.” Staff told us, “I treat them (people) the way I would want my mum to be treated I would be happy for my mum to live here.” People were able to personalise their room with their own furniture, personal items and choosing the décor, so that they were surrounded by things that were familiar to them.

Requires improvement

Is the service responsive?

Our findings

We observed examples of inconsistencies in the way staff responded to people's needs. One person required a hearing aid which they were waiting to be repaired. They said that when they are on their own it makes them jump when people come up behind them because they couldn't hear. When we asked staff and the registered manager about this they told us that the hearing aid had been sent for repair however it had been in the safe for three weeks. This had not been recorded in the person's care plan despite it stating that staff should "Ensure it is in working order" and that it would "Encourage X to feel involved."

We saw that on another occasion staff responded positively to a person who appeared to be in pain. The person responded "No thank you, I'm fine." Another member of staff asked someone if they would like a tissue to wipe their mouth as their lips were dry and offered them a drink to moisten them. We observed a person crying in the afternoon because they felt unwell. A staff member noticed immediately and went to comfort them.

Care given was not always based on individual's needs, care and treatment. Where people had specific health care needs such as living with dementia these had not been taken into account when planning the care or identifying what support they needed. Assessments were carried out before and after the person moved into the home, which provided information about people's needs and support. One person told us, "I believe a pre-assessment was done but they (staff) were supposed to come and see me hospital before I moved in. They must have done the pre-assessment over the phone with the hospital. I had no idea what I was coming to."

Pre admission assessments recorded individual's personal details and whether they had capacity to make decisions for themselves. Details of healthcare professionals such as doctor, dentist, care manager, information about any medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were documented. This information was reviewed before a care plan was developed and care and support given. This enabled staff to build a picture of the person's support needs based on the information provided.

Staff told us that they completed a handover sheet after each shift which relayed changes to people's needs. We looked at these sheets and saw, for example information related to a change in medication, healthcare appointments and messages to staff. Daily records were also completed to record support provided to each person; however they were very task orientated. For example X had a cup of tea; X had three sandwiches with eggs for supper and a cup of black tea. There was no information about interactions, activities or mood. This showed us that although there was up to date information about the support provided, the information was not person centred.

Failure to provide care and treatment in a way that is person centred is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the activities that were provided were not always what they wanted and were not always age appropriate. People told us they didn't get out enough and one said they thought that the activities were "Degrading." Another told us they were "Very, very bored." Relatives said that there was not enough for their family member to do. However others said that the activities suited them.

We saw that some people attended activities throughout the week and outside in the community. This information was displayed in pictorial format so people were able to identify what activities they would be attending. Staff told us, "We try to cater for various types of entertainment and at different times of day" and "We are going to have some trips out." Activities ranged from attending light exercise, listening to music, aromatherapy, manicures and board games. We also noted that pet therapy, religious services, cellist and violinist visited the home, which people enjoyed. We also saw photographs of outings people had attended. For people who did not want to participate in the scheduled activities, staff were available to undertake one to one engagement with them.

We recommend that the provider reviews individual hobbies and interests and look at ways and means these could be implement and people support to participate.

People and relatives confirmed that they were aware of the complaints system. One person told us, "I'll tell them if I am unhappy about anything." Another told us "I don't think my care would suffer if I complained."

Requires improvement

Is the service responsive?

People who had made complaints felt that the concern was taken seriously and dealt with in a timely manner. One person told us, "I did complain and they sorted it out." Another person with a specific health condition told us, "I made a complaint about the supper menu; they regularly change it without telling us. They kept replacing food with an alternative which is not good for my condition, I complained and they supported me, they took action."

We looked at the provider's complaints policy and procedure which was displayed at key points around the service. When people first moved in there was a copy provided in the service user guide which people kept in their rooms.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in place however we found that there was not effective management and leadership in the service. There was a lack of understanding or knowledge of people living at the service by the management team. For example there was confusion about the total number of people who lived in the service. For those people that required a DoLS application these had been made but there was no understanding of what stage the application was at or the outcome of these. We were told when we first arrived that no-one was unwell or had an infection however we later discovered that there was someone who was very unwell.

The registered manager had not notified the Care Quality Commission (CQC) about a number of important events which the service is required to send us by law. This meant that we would not be able to effectively monitor the service or identify concerns.

During the visit some of the staff told us that at times they felt they were unable to approach management when they needed help or support as they were worried about disturbing them. Others described the managers as being supportive. Some staff were unclear about the responsibilities of each of the managers which resulted in confusion for staff. We discussed this with the district manager who immediately organised a meeting to discuss staff concerns about the management team.

Care plan audits were undertaken monthly by the registered manager and deputy manager. We found that the action plans were not always followed up and missing information was not always identified by the audit. For example, one audit didn't pick up that there was no communication plan or social activities plan included for one person. Another found that the person's care plan needed updating to reflect their changing needs but this still had not been written in. These audits were done in May 2015. Care records did not always have up to date information about the person and the support required regarding their condition. Background information about their life was not recorded on their care plan.

We reviewed five daily observations of care practices forms from 21 May to 5 June 2015, where issues were noted, there was no recording of action taken. There was no information recorded by the manager after reviewing the document as per the instructions on the form. We reviewed daily Fluid balance chart for one person, staff had not followed instructions on how to complete the daily intake chart or recorded what action was taken when the person was unwell. We found that one person had been without a vital piece of equipment for 3 weeks as no-one had recorded that it was in need of repair. This meant there were ineffective systems in place to maintain an accurate and up to date record of the care and treatment provided. This also demonstrated that staff were not following the correct procedure as provided to protect people from improper care.

Audits to monitor the quality of the service were ineffective and did not identify areas of concern or that needed to be improved. We reviewed five months of audits on pressure care management and found they had exactly the same information written on each form and no action had been taken. These audits had not been verified by the care manager. We reviewed the Infection control audit dated May 2015, information recorded in this report alerted us that the service had an outbreak of sickness and diahorrea. Recommendations were made but there was no record of any action taken. The audit had not been verified by the care manager. There were audits on other areas such as maintenance of the service but any areas that needed addressing had not been actioned. One person kept reporting a smell from their room which they had reported twice but this had not been responded to and resolved.

We saw accident records were kept which contained a description of the accident, and if people required hospital treatment. Each accident had an accident form completed, which included immediate action taken, injury evaluation; follow up investigation and action taken. There was no analysis of these incidents and accidents completed to see if there were any trends that could be identified to help prevent these happening again. We reviewed the Accident /Incident investigation report dated February 2015, where a person was injured. The report identified issues which caused the injury and action to be taken. The information provided in this report identified that there were ineffective arrangements in place to monitor the care provided.

The lack of good governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the registered manager was approachable and visible throughout the service. One

Inadequate

Is the service well-led?

person told us, “The manager is about and she is very approachable, you can go down to her office anytime.” Another person told us, “The manager is always walking around, she is fine.” People and relatives were generally happy with the service provided and the care they received. Staff told us, “I think the home is well managed. The managers make a good team, there is an open door approach, and I feel supported.”

Staff told us there were regular staff meetings where they were encouraged to raise their concerns about the service. We saw minutes of the staff meetings dated 29 April and 13 May 2015 that noted items raised and discussed such new equipment, instruction about the laundry and sluice room, working as team, catering and training. The staff told us that they were aware of the complaints policy and procedure as well as the whistle blowing policy. Staff we spoke with had a clear understanding of what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously

We looked at a number of policies and procedures such as environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing. The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated that they were knowledgeable about aspects of this guidance. Peoples’ feedback was obtained in a variety of ways such as residents and relatives meetings, comments books, survey, discussions with people and their relatives. We saw results from a survey conducted in 2014, where the themes were staff and care, home comforts, choice and having a say and quality of life. We noted comments such as “The service is great,” “I would like more choice” and “The staff know my night routine.”

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 9 HSCA (RA) Regulations 2014 Person-centred care **The registered provider failed to ensure that individualised person centred care to people was provided. Regulation 9 (1) (a)(b)(c) and 3 (d) (i)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered provider failed to ensure that care and treatment was provided in a way that ensures people's dignity and respect. Regulation 10 (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered provider failed to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

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 17 HSCA (RA) Regulations 2014 Good governance The registered provider had not ensured good governance in the home.

The enforcement action we took:
Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider had not ensured there were sufficient staff deployed to meet people's needs. **Regulation 18 (1)**

The enforcement action we took:
Warning notice issued