Amicus Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 25 September and 1 October 2018. The inspection was unannounced.

Amicus Care Home Limited is a 'care home'. People in care homes receive accommodation and nursing and 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. Amicus Care Home Limited provides accommodation and support for up to 18 older people. There were 12 people living at the service at the time of our inspection. People had varying care needs. Some people were living with dementia, some people had diabetes or had suffered a stroke, some people required support from staff with their mobility around the home and others were able to walk around independently.

The service had a registered manager. The registered manager was also the provider. 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.

At our last inspection on 18 July 2017, the service was rated as 'Requires improvement.' We found continued breaches of Regulations12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to, the provider was not ensuring the safe administration of people's medicines; risk assessments were not effectively managing risks to people's safety. We added conditions to the provider's registration to ensure they kept us updated of improvements by reporting to CQC once a month to update on, new admissions to the service and their planned care and support; the review of staffing levels as a result of new admissions; actions taken as a result of regular audits of medicines administration records; actions taken as a result of result of regular auditing of risk assessments in place.

The provider sent their report at the end of each month as requested with the information required for CQC to monitor their progress in ensuring the safety of people in their care.

At the inspection in July 2017 we also found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to follow the basic principles of the Mental Capacity Act 2005 (MCA 2005). We added a condition to the provider's registration to ensure the provider reviewed capacity assessments for those people who lacked the capacity to make decisions relating to their care, to demonstrate they were adhering to the principles laid down within the MCA 2005. The provider was requested to report on this by 27 October 2017.

The provider sent a report by email on 25 October 2017 to confirm they had taken the action necessary to meet Regulation 11.

At this inspection, on 25 September and 1 October 2018 the service continues to be rated 'Requires

improvement. This is the third consecutive time the service has been rated Requires Improvement. The provider had made improvements in some areas. There was a greater understanding of the MCA 2005 and people were now supported to maintain their rights within the guiding principles of the Act. Peoples prescribed medicines were now managed in a safe way. Risks to people's safety were now appropriately managed. Improvements continued to be needed to the monitoring processes to ensure the quality and safety of the service are robust and consistently applied.

We found further concerns at this inspection around fire safety within the service. People had not been asked their views of the service to help to drive improvement.

Fire door retainers were not working as batteries were allowed to fail and not replaced. The battery failure of fire door retainers led to a constant bleeping which meant people were subject to the noise day and night and for an unspecified period of time. Fire alarm testing was not carried out regularly to ensure the safe working of the system. Fire evacuation drills had not been undertaken to make sure staff were able to practice the safe evacuation of people from the premises. Some people's personal evacuation plans did not suitably describe their individual support needs.

Auditing systems to monitor the quality and safety of the service were not used consistently or effectively. People's views of the service were not regularly sought or recorded in order to use their feedback to develop and improve.

Individual risks were appropriately identified and managed although the review process needed some improvement.

Staff knew their responsibilities in keeping people safe from abuse. Procedures were in place for staff to follow. The provider had worked with the local safeguarding team when concerns had been raised.

Accidents and incidents were appropriately recorded by staff, action was taken and followed up by the provider.

The procedures for the administration of people's prescribed medicines were managed and recorded appropriately so people received their medicines as intended. Regular audits of medicines were undertaken to ensure safe procedures continued to be followed and action was taken when errors were made.

Suitable numbers of staff were available to provide the care and support people were assessed as needing. The provider continued to make sure safe recruitment practices were followed so only suitable staff were employed to work with people who required care and support. Staff received training appropriate to their role, their competency was checked to make sure their work met the required standard. Staff told us they felt supported, they received one to one supervision.

The provider carried out an initial assessment with people before they moved in to the service. People were involved in the assessment, together with their relatives where appropriate. Each person had a care plan, the plans contained detailed guidance about people's choices and preferences. The care plan review process needed to be improved to ensure changing needs were recorded. We have made a recommendation about this.

People with a sensory impairment had a care plan to help guide staff with their support. Advice had not been sought from an organisation specialising in the support of people with a sensory impairment. We have made a recommendation about this.

People's end of life wishes had been recorded, staff supported people at the end of their lives according to their choices and preferences.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

People were supported to eat and drink a balanced diet, snacks and drinks were available through the day. People told us they were given a choice of food for their meals. Staff monitored people's health and referred people to healthcare professionals as needed, following the advice given. People had access to health professionals such as dieticians and opticians to keep them as healthy as possible.

Staff knew people well and people described staff as kind and caring. Staff respected people's privacy by knocking before entering their personal bedroom space.
People who refused baths and showers on a regular basis were not encouraged to regularly bath.

People had access to various activities. Some people preferred their own company and pursued interests such as reading or watching TV and this was respected by staff. People told us they knew how to complain and were confident that any complaints would be taken seriously.

People knew who the provider was and were able to speak to them when they wished. Staff told us they felt supported by the provider.

All the appropriate maintenance of the premises and servicing of equipment was carried out at suitable intervals. The service was clean and odour free and infection control practices were being used.

The provider had displayed the ratings from the last inspection, in July 2017, in a prominent place so that people and their visitors were able to see them.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Fire safety was not managed effectively to ensure the safety of people.

The assessment of individual risk had been considered and recorded. A more consistent approach to risk assessment reviews was needed.

The administration of medicines were managed to provide a safe service.

Accidents and incidents were recorded by staff and monitored by the provider. Staff followed safe procedures to control the risk of infection.

Suitable numbers of staff were employed and available to provide the care and support people required. The provider continued to follow robust recruitment practices.

The provider and staff had a good understanding of how to keep people safe from abuse and their responsibilities to report any concerns.

Is the service effective?

Good

The service was effective.

People's needs were assessed before moving in to the service and care plans developed accordingly.

People were supported to eat a balanced diet and were happy with the meals prepared and choices available.

People had access to advice and guidance from health care professionals.

The basic principles in relation to the Mental Capacity Act 2005 were followed and people's rights upheld.

Staff received the training they required to make sure they had

the knowledge to provide the care and support people were assessed as needing. Staff had the opportunity to have one to one supervision meetings with the provider.

Is the service caring?

Requires Improvement

The service was not always caring.

People were subjected to a constant bleeping noise from faulty fire safety equipment. People were not always encouraged to take the opportunity for baths and showers.

People thought the staff were kind and caring in their approach. Staff knew people well.

People were supported to maintain their independence. Staff were aware of people's privacy and respected this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place and included the information required for staff to provide individual care and support.

People were given the opportunity to take part in activities. Further opportunities for one to one support was being pursued.

People were encouraged to make plans for the end of their life if they wished to. Their cultural and spiritual needs were addressed through care planning.

Complaints were acted on quickly and appropriate responses were given following investigation.

Is the service well-led?

Requires Improvement

The service was not always well led.

Opportunities had been missed to make improvements through the quality audit and monitoring process. People had not been asked their views in order to shape the service to their wishes.

The recording of changes in peoples care and the outcome of reviews was not clearly recorded.

People knew the provider well as they were visible in the service. Staff felt they were listened to.

The service worked with other agencies to provide people with joined up care.	

Amicus Care Home Limited

Detailed findings

Background to this inspection

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

This inspection took place on 25 September and 1 October 2018. The inspection was unannounced on the first day and we told the provider when we would be returning to complete the inspection on the second day. The inspection was carried out by two inspectors and one 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.

Before the inspection, we 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. We looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We also looked at action plans sent in by the provider to tell us about the improvements they were making to address the concerns found at the last and previous inspections. We used this information to help us plan our inspection.

We spoke with eleven people who lived at the service and two visitors, to gain their views and experience of the service provided. We received feedback from one relative following the inspection. We also spoke to the registered manager and four staff. We received feedback from two health care professionals and one local authority commissioner.

We spent time observing the care provided in the communal areas of the service and the interaction between staff and people. We looked at seven people's care files, medicine administration records, four staff recruitment records as well as staff training records and the staff rota. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems.

We asked the provider to send us further information after the inspection and they sent this within a timely

manner.

Requires Improvement

Is the service safe?

Our findings

At the last inspection, on 18 July 2017, we identified continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not properly managed people's medicines. Risk assessments were not effectively minimising risks to people's safety.

At this inspection we found improvements had been made to the management of people's prescribed medicines. Improvements had also been made to the risk assessment process. However, we found new issues relating to fire safety.

On the first day of inspection, a number of fire door retainers were bleeping as the batteries were failing or had failed. A fire door retainer is a safe and legal way that allows fire doors to be held open safely, while automatically closing them in the event of a fire, when the fire alarm sounds. It is crucial the retainers are fully functioning otherwise there is a serious risk to people's safety if fire doors do not close automatically in the event of a fire. Some door retainers where the battery had fully failed were not keeping the fire doors open at all so staff had propped doors open by other means. The staff office door was kept open with a chair and a person's bedroom door was also propped open with a chair. The kitchen door leading into the dining room was propped open with a spoon. This meant in the case of a fire, these doors would not close automatically, losing the function of a fire door and placing everyone in the service at risk, particularly the people in those rooms.

We asked the staff how long the doors had been bleeping for and they were not able to give us a definite answer as they said they had been like this for a long time. The management team knew the fire door retainers required new batteries and could not explain why they had not been replaced. We urged the provider to replace the batteries as quickly as possible. We alerted the Kent Fire and Rescue Service of our concerns during the inspection.

When we returned for the second day of inspection, we found the fire door retainers continued to bleep and none had their batteries replaced. The provider and the quality assurance lead could not give an explanation why they had not acted in the intervening days to replace the batteries.

The provider had a weekly fire alarm check in place, however, these had not been carried out weekly. Out of the 26 weeks up to the date of inspection, the fire alarm was tested in only 14 of those weeks. This meant the provider could not be assured that the system in place to keep people safe from fire was working correctly. There was no evidence that the provider had ensured all fire doors closed as intended when the fire alarm sounded.

Evidence was not available to show that fire evacuation drills had been undertaken. No records were available. Staff were given practical training to understand the working of the fire panel and equipment. This did not include staff practicing and being observed carrying out an evacuation. The quality assurance lead confirmed they had not carried out evacuation drills. This meant that the provider could not be sure that staff could put their practical fire training skills into action or test if their evacuation procedure needed to be

reviewed.

Each person had a personal emergency evacuation plan (PEEP) to support their safe evacuation in the event of an emergency. However, these did not always identify the needs of some people. One person had a visual impairment. Their PEEP recorded that they had 'poor sight' and needed to be guided out of the building by one member of staff. Poor sight was not an accurate description of the person's condition as their care plan identified they were registered as partially sighted. No detail was documented of what staff should do if the person became distressed due to the noise and commotion of such an event. Evidence showed that the person became very distressed when the fire alarm sounded as a false alarm one day in January 2018. This experience was not used to review and update the PEEP.

On both days of inspection we found the airing cupboard had a sign on the door stating, 'Fire door, keep locked'. However, we found this door unlocked on both days. A hot water tank was also housed in this area which was hot to touch.

The failure to ensure people were kept safe from harm is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at Amicus Care Home Limited, "Absolutely safe"; "Always someone around at night."

The provider had made sure people were kept safe by identifying risks during personal care and around the service. Measures had been put in place to mitigate the risks to keep people safe from harm. Where people needed the assistance of equipment such as a wheelchair to support them to move from one area to another, potential risks to the individual had been documented. One person moved around in their wheelchair and were very clear they wished to preserve their independence. Risk assessments were in place showing the person preferred not to have the footplates or one armrest on as they found them restrictive. The provider had recorded that they had discussed the potential risks of making this decision and the person had agreed they understood but wished to stick with their choice. The risk assessment advised staff what to do to make sure the person remained independent but safe. Another person felt cold easily due to the medicines they had been prescribed. They wished to have a portable heater in their room so they could switch this on if they were feeling cold. The provider had completed a risk assessment to make sure they could meet the person's request while at the same time keeping them safe.

Some risk assessments required monthly review and some three monthly, depending on the level of risk. However, some risks had not been reviewed at the appropriate times. One person's falls risk assessment should have been reviewed each month but had not been reviewed since 19 July 2018. A risk assessment relating to a health condition should have also been reviewed monthly and had not been reviewed since 15 July 2018. A risk assessment of the person's bedroom environment should have been reviewed every three months and had not been reviewed since 5 June 2018. This is an area that requires further improvement.

People's medicines were managed safely, people received their medicines when they needed them. One person told us, "Medicines are always on time, I don't have to worry about remembering to take them." Staff received training to administer medicines and their competency was checked. We observed a medicine round, staff were patient, giving people time to take their medicines.

Staff accurately recorded when they administered medicines. The temperature of the rooms and the fridge where medicines were stored were recorded, to ensure that they were stored within the recommended temperature for medicines to remain effective. Liquid medicines and eye drops are effective for a limited

period once the bottle is opened, all opened bottles had an opening date on them.

Some people were prescribed 'as and when' medicines, such as pain relief and medicines for anxiety. There were protocols in place for staff to follow about when to give the medicines, how often and the maximum dosage.

One person had chosen to be responsible for taking their own medicines. This was clearly documented in their care plan and there was evidence this had been discussed and agreed with the GP. Staff checked the person's medicines each month and recorded this on a medicines administration record (MAR). This meant the person could remain independent and the provider could be assured of their safety. Another person was prescribed anti-coagulant medicines which are used to thin the blood to prevent clotting. A risk assessment was in place setting out the risks of taking this medicine, such as bruising and increased risk of bleeding. Guidance was in place for staff advising what to look out for and what to do if they were concerned.

Staff had a good understanding of their responsibility to protect people from abuse. Guidance and advice for staff about how to report a concern was available through a safeguarding procedure. Staff described how they would raise any worries they had with the provider and they were aware of who to contact outside of the organisation. Safeguarding referrals had been made to the local authority by the provider when necessary. Safeguarding incidents had been investigated and recorded appropriately.

Incidents and accidents had been recorded and analysed. The provider reviewed all incidents, identifying any trends or patterns. Action had been taken to reduce the risk of them happening again. As a result of analysis, some people had been referred to health care professionals to gain advice in keeping people safe by reducing the number of falls they experienced. Lessons learned from incident analysis were shared with staff at handovers and by messages left for all staff on noticeboards.

Staff told us they thought there were enough staff to be able to meet people's needs. They confirmed this was because the service had vacant rooms and if the service was full they would need more staff. Two staff were on duty on each shift. Staff told us they spent their time assisting people with their care and support needs, however extra time to spend sitting and chatting with people was not always available. The people we spoke with told us they thought there were enough staff. We were also told by people that their call bells were answered quickly, suggesting enough staff were on shift. One person said their call bell had not been answered quickly the previous night. However, they said this was not usually the case.

Safe recruitment practices were followed to ensure that staff were suitable to support people living in the service. The provider checked written references and their employment history, employment gaps had been discussed. Disclosure and Barring Service (DBS) criminal records checks had been completed before staff began work at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

The service was clean and odour free. A domestic staff member was employed to take responsibility for the cleaning tasks around the service. They followed a cleaning schedule which was kept up to date. Personal protective equipment such as disposable gloves and aprons were available and being used by staff when providing personal care. This helped to prevent the spread of infection within the service.

All essential works and servicing were carried out at appropriate intervals by the appropriate professional services including, fire alarms and equipment; gas safety; electrical safety; lifting equipment; legionella testing.

Good

Is the service effective?

Our findings

People were complimentary about the food and told us they were able to ask for something different to the menu if they wished. The comments we received included, "The new cook is nice, we had a lovely lunch on Sunday, lamb with mint sauce, it was delicious"; "If there is anything I don't like I just tell the cook and she makes me something I do like"; "The food is good, plenty of drinks."

At the last inspection on 18 July 2017, we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not followed the basic principles of the Mental Capacity Act 2005 to ensure people's rights were upheld.

At this inspection we found improvements had been made to preserve people's basic rights within the principles of the Mental Capacity Act 2005.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA 2005). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had made appropriate applications to the supervising authority. The provider kept the applications and authorisations under review. Mental capacity assessments had been undertaken where it was understood people may not have the capacity to make particular decisions.

The provider made sure decisions were made in people's best interests if they lacked the capacity to decide themselves, by including others who were involved in their lives. The provider had contacted the family members of those people who were not able to give their consent when the district nurse made arrangements to visit the service to administer flu vaccinations. One person's family member responded saying their loved one chose not to have vaccinations through their life when they had the capacity to make their own decisions. The family member felt therefore that they should not be subject to this now. The provider was able to use this information and the family member's opinion to inform a decision in the person's best interests.

Care plans documented if people were able to make their own choices and decisions and when people may require support with some more complex decisions. Where people needed help with making choices around day to day tasks, staff were given guidance through the care plan. People told us they were able to make their own choices and decisions, "I can go to bed and get up when I like. I go to bed at 11.00pm"; "I dress myself, choose all my own clothes, I'm very independent. I put my own clothes away otherwise I can't find them." One person had made it clear they wished to administer their own medicines and they also wished to choose and make arrangements for their own opticians and dentist. Where people's capacity or understanding fluctuated, this was recorded.

Some people had made arrangements for a family member or friend to act as Lasting Power of Attorney

(LPA) in the event of their not having the capacity to make decisions about their finances or health and welfare. Where this was the case, it was clearly recorded in their care plan and the provider had asked the LPA for a copy to confirm the arrangement. This meant that people's rights were respected and upheld.

People's needs were assessed and their care was planned to ensure their needs were met. The provider undertook an initial assessment with people, and their family members where appropriate, before they moved in to the service. The assessment checked the assistance people needed with all elements of their personal care throughout the day including, skin integrity; communication; continence; mobility and falls; medication and pain; psychological/emotional needs; sleeping; personal care/washing and dressing. The assessment identified what support was needed and this was used to develop the care plan. This enabled the provider to make an informed decision whether the staff team had the skills and experience necessary to support people with their assessed needs.

Some people chose to eat their meals in their room and some ate in the dining room. One person's care plan showed they liked to eat their meals in the dining room with other people. We observed that they sat in the dining room on both days of inspection. People's likes and dislikes regarding food were documented. One person's nutrition care plan showed that if breakfast arrived late they were likely to refuse it. Sometimes this may be because the person was asleep when breakfasts were being served. The care plan advised staff to continue to encourage but if they continued to refuse to respect their wish and offer snacks through the morning. The care plan could be enhanced further by speaking to the person and confirming whether they wished to always be woken up for breakfast if they were sleeping and adding this into the care plan.

Staff closely monitored people's weight and sought advice from dieticians when weight loss occurred. Care plans showed that advice given, such as high calorie diets or encouraging supplements was followed. The cook was informed of people's dietary requirements when they first moved in to the service and were kept up to date with any changes.

People were supported to access support for their health needs. Close links were in place with the local GP surgery who responded to requests for visits. Referrals were made to other health care professionals when needed. We saw that people had been referred to district nurses, nutritionists and dieticians, community mental health teams and opticians and dentists. Health care professionals were visiting on the day of inspection. They told us they had visited a person the previous week and had given advice for staff to follow. On their return, they told us they had found that staff had followed their advice as directed.

People's general health and diagnoses were recorded to make sure staff had an understanding of their needs. One person who was living with dementia often called out saying they were in pain. The provider had made contact with the dementia support nurse team who visited and had come to the conclusion the person was not experiencing physical pain but emotional distress. A referral had also been made to the community mental health team. Individual care plans were in place detailing the support people needed with their mouth care. Clear guidance was in place describing whether people were independent in this area and what they needed in place to help them. Where people required support to clean their teeth or dentures, the guidance for staff was detailed to assist people to maintain their oral health.

Staff received training appropriate to their role. New staff completed an induction programme, this included shadow shifts, to learn about people's choices and preferences. Staff received training in topics to enable them to support people and keep them safe. Training was completed online and face to face for some subjects such as moving and handling. Staff received training in topics specific to the people they supported including diabetes and dementia care.

Staff received one to one supervision from the provider although this had not been regular over recent months. Most staff had met individually with the provider in the last two months to discuss their performance and any concerns they may have.

Signs were in appropriate places to assist people to find areas such as the bathroom, dining room or lounge. People's bedrooms had their names and the room number to help them to identify their room if they forgot. Bedrooms had people's personal belongings and some people had brought their own furniture to use.

Requires Improvement

Is the service caring?

Our findings

Some fire door retainers were bleeping due to the batteries failing. These included people's bedroom doors. The bleeping continued when the doors were either open or when they were closed, so the noise was constant. The bleeping noise was noticeable throughout the service but worse for those whose rooms were affected. We spoke with people whose room fire door retainers were faulty. One person said, "My daughter mentioned it just yesterday and said it was a nuisance." The person said it was "annoying". Although we advised the provider to prioritise changing the batteries the bleeping noise remained on the second day of inspection. One management team member said, "You get used to it and don't notice it after a while." A staff member said, "It must drive people mad, it would me. It's only the batteries that need changing." The inspection team found the beeping noise irritating as it was a noise that did not stop.

The provider failed to ensure people were protected from a constant noise that invaded their personal space and may be detrimental to their well-being.

There was evidence that some people did not have access to regular baths or showers. At times staff recorded that people had declined and we saw in people's care plans that they did not always like to bath or shower. However, the records did not show that staff continued to encourage and support people to feel confident in accepting regular baths or showers where health or mobility issues did not prevent this.

One person's bath records showed their last shower was taken on 3 August 2018, previous to this they had one on 12 July 2018, one in June and one in April. Staff had recorded that they had declined one shower in June and one in April. Prior to this, their last bath/shower was 20 September 2017. This meant only four baths/showers had been taken in one year. No bath records were kept for another person. A further person had 11 baths/showers over the last 23 weeks.

People thought the staff were kind and caring towards them. People told us, "Not one carer (staff) I could fault, they help me all they can"; "The girls (staff) are very good"; "I am well cared for, the carers (staff) are very nice, they are very kind."

We saw staff using a caring approach when chatting with people. Staff knew people well. One member of staff spoke with one person, asking if they would like cake or biscuits. The person said they would like cake and they wanted two pieces, as they wanted one for the children. The member of staff returned with two slices of cake and gave these to the person. The staff member had a kind and gentle approach. The person had forgotten they had been asked about the cake and asked the staff member why they had given them cake. The staff member replied, "It's because I love you." The person smiled and said, "My mum loved me too."

We saw staff knocking on people's doors before entering. People confirmed staff respect their privacy and always knocked before entering their personal space. One person said, "They (staff) always knock before they come in."

People were supported to maintain their independence. Care plans recorded what people were able to do themselves and the areas they required staff support. We saw people who were able to, moving around independently in their wheelchair and people walking around the home as they wished. One person's washing and dressing care plan recorded that staff should encourage independence, such as 'Give [the person] the flannel and ask [them] to wash certain parts of [their] body to promote independence'.

People were asked at assessment if they had a religious faith and if they required assistance with their cultural needs. This was shown in their care plan. People living in the service at the time of inspection either described themselves as Christian or did not practice a religion. People told us if they wished to take a part in a religious ceremony or to speak to a spiritual leader this would be arranged for them. One person was Roman Catholic and it was important to them to have links with their local church. They also spent time through the day in prayer and quiet contemplation. This was recorded in their care plan and staff were able to describe to us how important the person's religion and spirituality was to them. Staff were aware of other religions that people may require support to observe and said they would access the support needed when required.

Independent advocates had been used to provide a voice for people when they did not have capacity to make their own decisions and had no known family members or next of kin. An advocate is an independent person who can help people express their needs and wishes, weigh up and make decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Requires Improvement

Is the service responsive?

Our findings

People told us they would be comfortable making a complaint and knew who to complain to if they needed to. The comments we received included, "The manager is always available and approachable. I would be happy to make a complaint if I needed to"; "I wouldn't have any problem complaining if I needed to, I would talk to the manager. But I would probably leave it to my daughter."

The provider had a complaints policy, this was displayed in the hallway of the service, clear for people and their visitors to see. The provider had dealt with complaints quickly and according to their complaints procedure. Complaints made had been mainly by people living in the service. Responses were appropriate and apologies were made where necessary. Family members were updated where appropriate.

Care plans were person centred, focusing on the individual and their wishes and needs. People's care plans contained the detail needed to enable staff to support people in the way they preferred. One person's care plan described that, although they needed full staff support, if they were in a good frame of mind then they were able to follow instructions to take part and carry out some tasks themselves. The care plan showed that morning is their best time and they were more likely to accept support and encouragement from staff at this time of the day. People who were able to articulate their choices had clearly been involved in planning their care. Although people's relatives appeared to be involved in care planning this was not always evidenced.

One person was registered as partially sighted and their care plan recorded they could see shadows and light only. Their previous interests included their love of reading and also listed their favourite author. It was also recorded they liked watching television previously, however could not see it now. The person's family member had tried to interest their loved one in talking books but it was recorded in the care plan that the person could not see the buttons to press in order to continue. Their care plan advised staff the person needed a quieter environment if they were anxious when in the lounge area. It was suggested they listen to music or that they may enjoy staff reading to them, however there was no evidence in the person's records that this regularly happened. We did see the person sitting in a quiet lounge area alone on the first day of inspection and a member of staff called in to speak to them regularly. Advice had not been sought from an organisation specialising in the care and support of people with a sensory impairment. We recommend the provider seeks advice from a reputable source to enhance the opportunities available for people with a sensory impairment.

A personal profile had been completed for each person, listing their likes and dislikes and whether they enjoyed joining in with activities or not. People's previous interests were included and if they wished, or were able, to continue with these. Detail of their life until now was included, for example, siblings; employment; marriage; children; interests; musical tastes. One person's personal profile described how they had enjoyed travelling through their life and had visited many places. They had also loved yoga and had practiced to a high level. People's personal profiles were individual and captured the lives people had before moving into the service giving staff the information they needed to take a holistic approach to people's care.

People were supported to follow their wishes even when staff thought it may not be wise. One person preferred to sleep in their chair rather than the bed. They had been advised of the concerns this posed such as the risk to their skin integrity. As the person had the capacity to make their own decisions this was respected. Staff supported them to sleep in the place they wished while at the same time putting measures in place to ensure their comfort and safety.

Some people liked to spend time in the lounge to be with others and other people preferred to spend their time in their room. One person told us, "The activity leader is quite new, I play my own music and watch a little television, I do join in with the bingo." How to support people to avoid social isolation was recorded in their care plans. One to one time for individual activity was planned, although this was not often. One person commented, "The activity leader comes in my room and does exercises with me." However, other people felt they did not have enough one to one time to pursue their interests. The provider employed an activities coordinator, they worked two hours a day, five days a week, which meant the individual one to one activities were limited due to time restraints. Although staff spent time with people when delivering their personal care, they did not have time to spend outside of the task orientated periods. People did not have the opportunity to go out unless they had family members who could take them. One person was able to go out independently and we saw them going out for a walk on the day of inspection. The provider told us they were looking at ways to increase the time spent on activities and shared some of their ideas with us.

The activities coordinator told us they based the group activities on what people liked to do and how the group felt on any given day, "I plan the activities according to what people like to do, their interests and based on what they tell me. Not everyone is interested in doing similar things" and "I tend to plan for the week, however this can change on a daily basis, depending on who comes to the sessions. I keep it flexible."

People were asked what their wishes were for their care at the end of their life. Some people did not wish to discuss this subject, or had confirmed their family members knew what they wanted and would take care of this, and this was recorded. Other people had been clear about their future wishes. One person who was a practicing Roman Catholic had requested they receive the last rites from a Catholic priest when they were near the end of their life. The name of the local priest was recorded in their care plan. Although this particular priest had recently left, the person told us they were waiting to meet the new priest. Staff confirmed they knew the person's wishes and needs and they also knew that a new priest was in position at the local church.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, on 18 July 2017, we identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not operating an effective quality assurance system and had failed to maintain accurate records.

At this inspection, we found although some small improvements had been made, there was still need for further improvement.

The provider had auditing and monitoring processes in place. However, the systems were not robust and a consistent approach had not been taken to ensure the safety and good quality of the service was maintained. The range of audits to be undertaken included, risk assessments; care plans; medicines; health and safety; infection control; pressure area care; handover records; dignity observations; lunchtime observations. Of these, only risk assessments and medicines audits were completed regularly and action taken to improve where issues were found. An infection control audit had not been completed at all, only blank sheets were available. A selection of people's care plans were audited by the provider on a monthly basis. However, the approach was not consistent. Where areas of the care plan were found to be needing attention, the action required to make the improvements was not always recorded. One person's care plan had been audited. The audit sheet recorded risk assessments were required for 'behaviour' and 'wandering'. No further detail was documented to show the date of the audit, what action needed to be taken or by who. This meant the provider could not check to make sure the improvements had been made. We checked the person's risk assessments and the two referred to in the audit were not in place.

A health and safety audit should have been completed monthly, however, we found records for May and August 2018. We were told the September 2018 audit had not yet been completed as it was due at the end of the month. We checked and found that the auditor had recorded fire door retainer batteries needed replacement in both May and September 2018. The audits did not record which doors were affected. No completion dates had been recorded for any of the actions noted. Documentation for 'dates to be actioned by' were recorded as 'immediate' or 'as soon as possible' and a staff member had not been identified to take responsibility for the action. Actions that should have been taken had not. The auditing process, designed to monitor the quality and safety of the service had failed.

People's daily records had not always been completed appropriately. Fluid charts were completed by staff where people's health condition showed their fluid intake needed monitoring. However, these were not totalled up at the end of the day or as a running total throughout the day. The amount of fluid each person was expected to drink in a day was not recorded on the chart to enable staff to support each person to drink their recommended amount of fluids to maintain their health. This meant the provider or staff could not easily monitor people's fluid intake to assess whether further intervention was required from a health care professional. When we checked and totalled a selection of fluid charts the amounts of fluid taken in a day across a four day period ranged from 540mls to 1550mls for one person and between 800mls and 1350mls across a four day period for another person. In the absence of a recording to show how much fluid each of the two individuals should have taken in a day it was not possible to establish if they were receiving enough

fluid to maintain their health. Fluid charts that should have been used to record one day's fluids on one side of the sheet had two days of documentation, making many recordings unclear.

Regular meetings with people living in the service and their family members or friends were not held, the last meeting was recorded as taking place in May 2015. The quality assurance lead told us as they were receiving referrals from people with higher support needs presently, not many people could participate. However, this was not our experience – we spoke to people who were able to articulate their view. The provider told us they and the staff chat to people and visitors every day. However, there were no records of people or their visitors being asked their views of the service through these chats. The last survey had taken place in February 2017 and only one completed survey from a family member, was evident in the file. The provider had not taken opportunities to ask people and others, such as visitors, for their feedback of the service. This meant the provider did not have a process to listen to people and make appropriate improvements to create a better quality experience for people living in the service.

The failure to ensure a robust approach to measuring the quality and safety of the service through a successful auditing process and a mechanism to listen to and record people's views is a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were not consistently reviewed to reflect changes in people's care. Although dates of reviews were recorded on each care plan, the details were not recorded. 'No changes' was occasionally recorded but most times, just the date was written with no other comments. Changes were handwritten which suggested a change had been made but these were often not dated and no reference was made to a review having prompted the change. One care plan had been developed in June 2016 and dates of review were recorded every month with no comments made or 'no changes' occasionally recorded. Review dates were recorded every month until March 2018 when no further review dates had been recorded. This was a consistent feature throughout most people's care plans. We recommend the provider seeks guidance from a reputable source to develop a system for appropriately reviewing and recording changes to people's assessed care needs.

The service had a registered manager.

The provider did not hold regular staff meetings, the last one recorded was dated June 2017. When we asked about this we were told there were not many staff at the present time so they were not needed. The provider said as they were in the service every day they could chat with staff at any time. Staff told us the provider did have a meeting with the staff who were on shift if they needed to discuss an item.

The provider told us they worked closely with other service providers and registered managers in the local area. The provider also worked with other agencies including the local safeguarding authority, local commissioning group and health care professionals.

People knew who the provider/registered manager was and felt confident in approaching them if they wished to discuss anything, "If I have any worries I talk to the manager"; "Good manager, very approachable."

A member of staff said, "I feel confident to ask the manager if I need any support. She is always available if we need to talk to her."

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. CQC check that appropriate action had been taken.

The provider had submitted notifications to CQC in an appropriate and timely manner and in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating is given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The rating was prominently displayed at the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people were kept safe from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure a robust approach to measuring the quality and safety of the service through a successful auditing process and a mechanism to listen to and record people's views.