Viomar Care Homes Limited

The Old Vicarage Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 30 and 31 July 2018 and was unannounced.

The Old Vicarage Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Care and support is provided in one building with a communal lounge and dining room. The Old Vicarage Residential Home is registered to provide care and support for up to 15 people. At the time of this inspection 15 people were using the service.

There was a registered manager. 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.

This was the first inspection since this service was registered on 25 February 2017. The home was rated 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

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

Risks to people's safety, health and wellbeing were not always suitably assessed and managed.

There was not always enough suitably skilled staff deployed at night time to administer medicines to people if this was required. Staff were not always trained to provide safe and effective care.

People were not always protected from the risks of avoidable harm and abuse because incidents of possible abuse were not always identified and reported to the local authority as required. Action was not always taken to protect people from further occurrences.

We found that medicines were not managed safely and people were at risk of not receiving their medicines as directed by the prescriber.
Safe recruitment processes were not always followed when employing new staff members and volunteers.

Systems in place to consistently assess and monitor risks to people and the quality of care provided were not operated effectively. This meant that issues with the safety and quality of the care were not reliably identified and rectified.

People were not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible.

People did not always receive an apology when things had gone wrong.

We were not always notified of events that are required by law.

People told us they had access to healthcare professionals when they required them however, we found that professional advice was not always incorporated into people's plans of care.

People had choices of food and drinks. However, people's nutritional risks were not always managed.

The provider did not have effective infection prevention and control practices in place.

People's privacy and dignity was not always respected and promoted.

People told us that staff treated them with kindness and compassion. People had choices though they were not always enabled to share their views.

People did not have access to activities they enjoyed.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

People's risks were not always suitably assessed and managed to keep them safe. People's medicines were not always safely managed to ensure they received them as prescribed.

People were not always protected from avoidable harm and abuse.

There were enough staff to meet people's needs though their suitably to work with vulnerable people had not always been suitably assessed. There were not always staff trained administer medicines on duty at night time.

People were not consistently protected from the spread of infection.

Is the service effective?

Inadequate

The service was not effective.

People were not always supported to consent to their care and treatment in line with law and guidance.

Staff were not always suitably trained to provide effective care to people. The provider did not have a suitable system in place to ensure staff were suitably skilled and competent.

People had choices about their food and drink but nutritional risks were not always managed well.

People had access to healthcare professionals but professional advice was not incorporated into care plans to ensure it was followed by staff.

Improvements were required to the adaptation and design of the service to ensure it met people's needs.

Staff felt they communicated well between themselves when passing on information about people, however records we saw did not always support this view.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy and dignity was not always protected and they were not always enabled to share their views.

People had choices.

Staff were friendly and treated people with kindness, showing regard for their wellbeing.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care because they were not involved in developing their own care plans. Some care plans were not up to date.

People were not supported to follow their interests and did not have access to meaningful activities.

People felt staff knew them well and staff knew people's preferences.

People's wishes for their end of life had not been considered.

People felt able to complain if required and complaints were dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

There were no suitable systems in place to monitor the quality and safety of the services provided and suitable plans had not been developed to drive improvements.

The registered manager did not understand all the requirements of registration with us.

People, relatives and staff felt the registered manager was approachable and supportive.

The Old Vicarage Residential Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of an incident whereby a person using the service suffered abuse. This incident was investigated by the local authority safeguarding adults team. The information shared with CQC about the incident indicated potential concerns about the management of risks. This inspection examined those risks.

This inspection took place on 30 and 31 July 2018 and was unannounced.

The inspection team consisted of two inspectors and an evidence reviewing officer who was shadowing the inspection on day one. Day two was completed by two inspectors.

Before the inspection visit, we checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed information we had received from the public, commissioners and the local authority safeguarding adults team. We used this information to help formulate our inspection plan.

We spoke with six people who used the service and four visiting relatives. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with four members of care staff including a cook and a domestic assistant. We spoke with the registered manager and the providers to help us to understand how the service was managed.

Some people who used the service were not able to speak to us about their care experiences so we observed how the staff interacted with people in communal areas and we looked at the care records of six people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included five staff files, meeting minutes, training records and quality assurance records.

Inadequate

Is the service safe?

Our findings

The risks to people's safety and welfare were not always suitably assessed and managed. For example, one person was at high risk of falls. Their care plan stated that staff needed to be aware that the person often tried to get out of their chair unassisted. This staff awareness was to prevent falls occurring. The person had a history of falls which had occurred when they had tried to stand to get to the toilet without staff support. However, we saw the person was mostly unsupervised in their chair in the lounge and there had been no consideration of assistive technology that could have alerted staff to when the person needed assistance to move. This meant that the identified risk of falls for this person, was not suitably managed or mitigated.

Risks to people's skin including the risk of developing pressure sores were not suitably managed. One person's risk assessment stated they had no current pressure sores but that blanching (skin turning pale) had previously been noted to their ankle. To manage the risk of skin breakdown, the plan stated they should have a specialist cushion and mattress and we saw these were in place. However, it also stated they should have a barrier cream applied twice daily to prevent pressure sores. We found the person had no barrier cream in stock and had not been having this treatment. We asked the registered manager about this and they told us this was a new risk assessment and had only been implemented on the day of the inspection and so the cream had not yet been ordered. This meant the person's risk was not suitably managed as the current risk assessment was not being followed.

Some people had diabetes and the risks associated with diabetes were not safely managed. One person had a specific risk assessment but it was not robust and did not provide staff with the detail they needed to safely manage the risks. It stated that blood sugar readings should be taken 'regularly' but did not state how often, at what times, what was a safe blood sugar level for the person or what action staff should take if they were concerned. When a person experiences a hypoglycaemic (low blood sugar) or hyperglycaemic (high blood sugar) episode, immediate action can be required to prevent a person from becoming more ill. There was no information for staff about what signs to look out for or what action taken take. Staff gave differing accounts of what was a safe blood sugar reading for the person with one staff member stating that a reading over nine would be a concern and the registered manager stating anything over 16 would be a concern. Best practice guidelines state that a normal blood sugar reading for a healthy individual is up 7.8. Records showed that blood sugar readings had been as high as 32.7, 27.4 and 22.0. The provider told us that a doctor had been contacted on these occasions but it was not clear what action staff should take and at what point. The cook told us they had received no training from the provider about diabetes and how to provide a suitable diabetic diet. There was no guidance to help staff recognise deterioration in a person's diabetic condition and staff we spoke with were unable to explain the actions they needed to take.

Staff told us there were occasions when some people were unable to weight bare and staff were unable to support them to move safely, because there was no hoist or other equipment to help them move safely on these occasions. This risk was not assessed and there were no plans in place for staff to follow. Additionally, some people were at risk of falls. The lack of suitable equipment meant that staff were reliant on paramedics to help people safely get up from the floor if they had fallen. Staff told us they had raised their concerns to the registered manager and the registered manager said they had asked the provider to

purchase suitable equipment. However, this was not yet in place which meant there was a risk that people would not be supported to move safely.

People's medicines were not safely managed to ensure that they received them as prescribed. Some people were prescribed 'as required' pain relief medicines. Suitable protocols were not in place to guide staff on how to administer these medicines to people who were unable to request them. A senior staff member told us that not all people were able to verbally communicate that they were in pain. There was no guidance to tell staff how people communicated pain or signs to look out for. Additionally, the registered manager told us that only senior staff were trained and able to administer medicines. However, they told us that senior staff were not always on duty at night time, which meant people would not be able to access any pain relief medicines during the night, should it be required. These issues meant there was risk that people may not receive their pain relief medicines when they needed them.

Some people were prescribed topical creams. However, the medicines administration records (MARs) showed many gaps so we could not be sure that people were receiving their creams as prescribed. One person was prescribed an anti-inflammatory and pain relief gel to be applied three times daily. However, the hand-written MAR stated that it should be applied twice daily. We found that some people had creams prescribed but there was no MAR in place. These issues meant people were not receiving their topical medicines as prescribed.

We found that topical medicines were not stored securely which was not safe practice. People could have accessed medicines which were not prescribed for them and as the home supported people living with dementia who may pick these up in error, they were exposed to the risk of harm. Medicines stock control was inconsistent. We checked stocks of some people's medicines and found they did not tally with the MARs so we could not be sure they were receiving their medicines as prescribed and as recorded. Excess stocks of medicines were kept elsewhere in the home which meant there was not a complete and accurate record of people's medicines that were onsite. The provider did not have an effective system in place to ensure the safe and proper management of medicines.

The above evidence demonstrates that people did not always receive safe care. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who lived at the home smoked. There was a smoking area located next to the refuse bins which we saw people accessed unsupervised. There was a container for cigarette ends and matches located next to the bins. We saw that people threw their matches and cigarette ends near to the container but often missed. There was no risk assessment in place to consider the risk of people smoking and disposing of smoking paraphernalia near to the bins. We saw that there was a trip hazard on the flooring of the doorway to the smoking area. People accessing the smoking area were at risk of falls and used walking aids including walking frames. A staff member told us they had reported this concern but no action had been taken. We shared these concerns with the provider following the inspection and they acted to ensure that the smoking area was safe for people to use.

Whilst staff we spoke with told us they knew how to recognise potential abuse and would report their concerns to the registered manager, we found people were not consistently protected from avoidable harm or potential abuse. We found that unexplained injuries to people had not been investigated and/or reported as a safeguarding concern. For example, the accident book showed unexplained injuries to people including scratches, skin tears, unexplained bleeding and a cut to the bridge of the nose. No further action had been taken to safeguard the person from further injury. There were no records that showed these concerns had been investigated or reported to the local safeguarding authority for investigation. This meant the provider

could not be sure how these injuries had occurred as no action to investigate had taken place and therefore no plans were put into place to reduce the risk of a similar injury occurring again. A staff member said, "I would document any concerns and talk to the registered manager." We spoke with the registered manager about their role in safeguarding people from abuse and improper treatment and found that their knowledge was lacking. They told us they would monitor unexplained injuries and did not consider the need to investigate the cause or safeguard people from the risk of further injuries. We looked at one person's daily records and found they had assaulted other people who used the service on more than one occasion. The registered manager confirmed they were aware of these incidents but they had not instigated a referral to the local safeguarding adult's team in line with safeguarding adult's procedures and there had been no risk management plans implemented to protect people from further risk of assault.

Despite an incident occurring where a person experienced abuse, we found that the registered manager still lacked knowledge and understanding of safeguarding adults procedures and had still not taken action to ensure people were safeguarded from potential abuse. This meant that lessons had not been learned when things went wrong and the required improvements had still not been made.

The above evidence demonstrates that people were not always safeguarded from abuse and improper treatment. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider could not be sure that staff were safe and suitable to work with vulnerable people who used the service because robust recruitment practices and oversight were not in place. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure staff were suitable to work with people who used the service. However, when staff had convictions, a suitable risk assessment had not always been carried out to ensure that they were safe to work with people who used the service. We also found that a volunteer was working at the service without a suitable risk assessment in place.
The above evidence demonstrates that the provider could not be sure that staff employed were suitable to work with people who used the service. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt there were enough staff to meet their needs. One person said, "You only have to ask and they [staff] are there." The registered manager told us there were two care staff on duty at all times and that this was, "generally enough". A staff member said, "Two staff is usually enough. We have got enough time to provide the support that people need. Some days, if people are unwell for example, we are stretched but generally it's OK." The registered manager told us that care staff would call on them to support people if this was required. However, the registered manager had not ensured that suitably skilled staff were always available to support people because there was not always a staff member trained to administer medicines on duty during the night. The registered manager said, "It's something I'm aware of but staff will ring me in the night and I will come in if needed." This was not appropriate measure to ensure people had access to the timely support they required and meant that suitably skilled staff were not always available to people.

People were not always protected from the spread of infection. We observed that toiletries including bars of soap and razors were left out in bathrooms. We asked the registered manager if communal toiletries were used and they told us that each person had their own toiletries which should be taken back to their rooms following personal care. We saw this had not happened which meant there was a risk of people using others' soap or razors which presented an infection control risk. We found that not all the bathrooms contained hand soap or a bin to dispose of paper towels. We asked staff about this and they told us they would usually go into another bathroom to use soap or dispose of paper towels. We told the registered manager and they

provided soap, however this showed that there were not always facilities available for staff to wash and dry their hands in line with infection control practices. Staff told us they used personal protective equipment (PPE) including aprons and gloves to prevent the spread of infection. However, we saw that plastic gloves were left lying around in bathrooms and on top of a fire extinguisher outside a person's room. It was unclear whether the gloves had been used or not and this presented a risk to people living with dementia who used the service and could access the PPE.

Inadequate

Is the service effective?

Our findings

The principles of the Mental Capacity Act 2005 (MCA) were not followed correctly to ensure people consented to their care and their rights were protected. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Some staff we spoke with did not have a good understanding of the MCA, so they were unaware of their responsibilities in supporting people's decision making.

Training records showed that all staff had not completed training on the MCA and that training on the MCA had only been introduced in June 2018, so the provider had not taken adequate steps to ensure that staff understood and were able to follow the MCA. One staff member said, "I've not been provided any training on it [The MCA]." We found that when people's capacity to consent to their care had been assessed, the assessments did not comply with the principles of the MCA. For example, one person was assessed as having the mental capacity to understand and manage their own medicines. We asked the registered manager if the person was managing their own medicines and were told that no-one could manage their own medicines because staff did this for everyone when they moved into the home. This meant that people were not supported to make their own decisions when they were able to. There was also no record of the person making an informed decision to delegate the responsibility of administering their medicines to staff.

The registered manager then told us the person lacked the mental capacity to manage their own medicines and that they had misunderstood the MCA and therefore incorrectly assessed people's mental capacity. This meant that people's needs and choices were not assessed correctly in line with current legislation and guidance. We found that some mental capacity assessments were not decision specific in line with the MCA. We also found that best interests decisions were not recorded when people were assessed as lacking mental capacity. These examples showed that people were not always supported to consent to their care and the MCA was not followed correctly to protect people's human and legal rights.

We saw that each person had an 'appointed decision maker' recorded in their care plan and this was usually a family member. However, there was no evidence that family members had Lasting Power of Attorney to legally make decisions on behalf of people. We found consent documents in care plans that showed next of kin had signed to give consent for medicines to be dispensed by the home. Next of kin has no legal powers to make decisions on behalf of person who lacks mental capacity. There was no evidence that family members had any legal decision-making authority and when they were recorded as Power of Attorney, the service had not requested evidence of this. The registered manager was unaware of the different types of attorney. This meant there was a risk that people were making decisions on behalf of people who lacked mental capacity, without the legal authority to do so.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the registered manager did not understand the reasons why DoLS authorisations would be required and therefore had not ensured that applications for DoLS authorisations were made when required. They told us, "All my mental capacity assessments will be wrong now, I have misunderstood it." Staff were unaware of which people had DoLS authorisations in place and DoLS paperwork was kept in a file that was not accessible to staff. This meant staff were unable to ensure that any conditions were complied with. We found that one person had a condition on their DoLS authorisation and this was not being complied with. This meant the principles of the MCA and DoLS were not being complied with.

The above evidence demonstrates that consent was not always sought and when people lacked the mental capacity to give such consent, the service had not acted in accordance with the MCA. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported effectively by staff who had the required knowledge and skills. The provider could not be sure that all staff had the relevant training and skills to provide support to people. Some care staff were working unsupervised, supporting people to move without having practical moving and handling training. The registered manager confirmed this to us. Staff told us, and records confirmed, that some people displayed behaviour which may challenge staff. The registered manager confirmed that staff had not received training to help them to understand how to manage these behaviours safely and effectively. This meant there was a risk of people receiving inconsistent support to manage their behaviours. When we looked the training matrix we found that some staff had not completed all the training they needed to support people effectively. Staff confirmed that their competency was not checked regularly to ensure their skills and knowledge were up to date, including medicines administration. This meant the provider could not be sure that staff had the skills and knowledge to provide effective care.

The above evidence demonstrates that the provider had not assured themselves that staff were suitably qualified, skilled and competent. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had a choice of food and drink. One person said, "There is a choice, not a lot like, they [staff] do ask though." We saw that one person was offered an alternative when they did not like the meal they had chosen. However, we saw that people did not always receive the support they needed to eat and drink. One person had a visual impairment and we saw they struggled to eat their meal without staff support. We heard them say, "I can't see what I'm eating." We observed them trying to eat but their cutlery was frequently empty of food because they could not see. They used their knife to eat for ten minutes before staff assisted them to swap their fork from their left to right hand and offered them a bowl instead of a plate. No equipment to help them eat independently had been considered or provided which meant the person did not have the help they needed to eat their meal.

Risks to people's nutritional status were not always effectively managed. Some people were at risk of malnutrition and dehydration and required their food and fluid intake monitored to ensure it was adequate and that necessary action was taken if it was low. We saw that some people had no such monitoring in place when there was an identified risk, so these risks to their nutritional status were not managed. One person was having their fluid intake monitored, however there was no system in place to check their daily fluid totals and take any necessary action required. Their monitoring chart did not state what their daily fluid target was and there was no running total. This meant that people's food and fluid intake was not adequately monitored when required to ensure they had enough to eat and drink. The cook told us that food was not fortified to try and help increase peoples' calorie intake.

People told us they had access to healthcare professionals when they needed them and their relatives confirmed this. A relative said, "[My relative] had a set back and the doctor was called [by staff]." Another relative said, "My relative's legs were badly swollen so the doctor was called. They [staff] rang and kept us informed." Staff told us that people had access to healthcare professionals, however their advice was not always incorporated clearly into people's care plans to ensure it was understood and followed by staff. For example, we were told that a physiotherapist had assessed one person and advised how they should be supported to move by two staff. However, details of the assessment and advice given was not easily accessible and was not incorporated into their moving and handling care plan and risk assessment. This meant that people were at risk of receiving support that was not in line with advice given by professionals because care plans were not updated and reflective of professional advice.

We saw that the environment had been adapted to help meet people's physical needs; however, improvements to the environment were required. Bathrooms had been adapted to help ensure that people with physical health needs could have their personal care needs met. However, we saw that one bathroom was used for storage of a hoist and chairs which meant that people could not safely access it. Staff told us there was a garden area but that people could not freely access it because it was not secure and therefore people had to wait for staff to support them to use this area. The provider had plans to address the issues with the design and adaption of the premises so that they more effectively met people's needs. To help people living with dementia to independently access their own bedrooms, there was already some dementia friendly signage in place and that people had photographs and personalised decoration of their bedrooms doors. Staff told us they had handover sessions at the beginning of each shift and that they were effective in ensuring that they had information they needed to deliver effective care to people. They told us that changes in people's condition were communicated between staff and we saw that daily records were detailed to show how people had presented. However, information such as people's fluid intake was not suitably totalled and passed over at handover sessions. There were no fluid target amounts so staff could not ensure that the target was achieved. This meant that staff communication between each other was not consistently effective and they did not always have the detailed information they needed to effective manage people's risks.

Requires Improvement

Is the service caring?

Our findings

People told us that their privacy and dignity was respected and promoted. One person said, "My privacy is respected because I am able to speak to my relatives alone if I want to." Another person said, "If I'm getting undressed, [staff] will ask if they should leave the room." However, we saw that people's underwear was left hanging on grab rails in communal corridors which meant that people's privacy and dignity was not consistently respected. We also saw that a person with a visual impairment did not always have the support they needed to eat. We saw they spilt cereal and milk over themselves and the table where they were sitting with others. This was not dignified for the person. Despite these issues, staff demonstrated that tried to promote people's dignity. A staff member said, "We know that one person will sometimes undress in the lounge because they get confused and think they are in their room. We are aware of this and make sure they are covered up if they do this."

People told us they were offered choices in their day to day care. One person said, "I can choose food and when I get up and go to bed." Staff told us how they encouraged people to make their own choices. A staff member said, "We offer choices to people. Sometimes it can take a while for people to make a choice, so we would perhaps offer two choices to make it simpler for people. You get to know what people prefer." However, people were not always supported to express their views and be actively involved in decisions about their care because the registered manager told us that people were not involved in their own care planning and reviews. People were not supported to be involved in regular resident's meetings or share their views on the care and support via regular reviews. This meant that improvements were needed to ensure that people could express their views and be actively involved in making decisions about their care.

People told us that staff were friendly and treated them with kindness and compassion. People told us, "They're very good, the staff" and "Anything you want, they [staff] help you with. I can't fault them." A relative said, "The friendliness if the best thing about the home. It feels like a family home." We observed that staff treated people with kindness and respect and showed regard for their wellbeing. For example, we heard staff say to one person, "Put your feet up for half an hour because of your poorly leg." They fetched a stool for the person to rest their legs and the person smiled at staff and looked comfortable. We heard another staff member say, "You're not too hot in this jumper, are you?" This showed that staff showed concern and consideration for people's comfort and wellbeing.

Requires Improvement

Is the service responsive?

Our findings

People did not receive consistently personalised care that was responsive to their needs. The registered manager told us that people were not routinely involved in their developing their own care plans and reviewing their care. This meant they were not given the opportunity to contribute to the planning of their own care and their preferences and wishes may not be captured and met. We found that some preferences were recorded, however some care plans were contradictory. For example, one person's care plan stated they had their own teeth and staff should support them to clean them. However, they had a risk assessment in place for support to care for dentures. This meant that care plans were not always accurate and up to date so staff did not have access to information they needed to provider personalised care. We found some personalised information about how people liked to be supported with their daily routine. However, it was kept in the registered manager's office and staff did not have access to it, which meant that this useful information was not being shared with staff.

Some people who used the service were registered blind and we found their needs in relation to this had not been suitably assessed and met. The registered manager was unaware of the Accessible Information Standard and their duties to provide information to people in a format they could understand. There was no consideration of adaptations the person may require or technology which may help to maximise their independence and meet their individualised communication needs.

We observed there was little activity or stimulation available for people. A relative said, "A few more activities would be good. People are not going out as there is no transport, there's no sing song or game of bingo or anything." We saw an activities timetable was displayed but we did not see the scheduled activities take place as planned. Staff we spoke with told us they were expected to provide activities for people but that they did not always have the time to do this. One staff member said, "I don't think there's enough for people. We [care staff] do a few bits if we get chance such as games but people don't get to go out at all and I think they should." Another staff member said, "I don't think there's enough to keep people stimulated. We are supposed to do something during the shift but there is not always enough time. Activities are hard to fit in." This meant that people were not supported to follow any interests and did not have access to activities they may enjoy.

People told us that staff knew them well and relatives confirmed this. Staff said they got to know people as it was a small home and a small staff team. We saw that people's needs and preferences were recorded. A staff member said, "Every so often someone from the church comes in and delivers communion and [one person]'s family take them to chapel." However, we spoke with the registered manager about people's other diverse needs including those in relation to the protected characteristics of the Equality Act. The registered manager was unfamiliar with the protected characteristics which meant there was a risk that all of people's diverse needs may not be assessed and met.

At the time of the inspection, no-one was receiving end of life care. However, we found that people's wishes for care and treatment at the end of their lives had not been considered or planned for. This meant there was a risk that people may not receive the care or treatment they would wish for because they had not been

asked at a time they were able to communicate their wishes.

People knew how to raise concerns and complaints and felt able to do this when required. One person said, "I would speak to the staff." Staff knew how to respond to complaints. A staff member said, "I would speak to a senior or the manager and document it. I think there is a policy though I've not come across it. I could access it if I needed to." There was an appropriate complaints policy in place and the registered manager had a complaint record to ensure that all concerns were recorded and acted upon. We found that when a concern had been raised, it was dealt with and responded to which showed that complaints were taken seriously and dealt with in line with the provider's policy.

Inadequate

Is the service well-led?

Our findings

People could not be assured that the care they received would be appropriately monitored to ensure it was safe and met their individual needs. Governance systems in place were not operated effectively to continually assess, monitor and improve the quality and safety of the services provided. For example, medicines audits did not identify the issues that we did during the inspection. This meant they were ineffective in identifying issues and therefore no action had been taken to make improvements. A medicines audit did identify that topical creams were not being applied as prescribed. However, the measures taken to improve this were not effective and no further improvements were implemented. The registered manager told us they had repeatedly asked staff to completed medicines administration records but they had not been done. This issue reoccurred on numerous monthly audits and still no effective action was taken.

There were no recorded audits of care plans, daily records or monitoring charts including food and fluids and bowel monitoring. This meant that the quality and effectiveness of these records were not reviewed and action was not taken to drive improvements. It also meant that required action was not always taken in a timely manner in relation to issues identified including low fluid intake and incidents. This resulted in people being exposed to the risk of harm.

Staff training was not suitably monitored and staff competency was not suitably checked. For example, training in the Mental Capacity Act 2005 was not available for staff until June 2018 and not all staff had completed this. When staff had completed this, we found their competency had not been checked to ensure that staff understood their responsibilities. Some staff we spoke with, including the registered manager, were unable to demonstrate an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

There was no effective analysis of incidents and accidents to look for trends and ensure suitable action had been taken. A falls analysis was completed; however, this did not always result in suitable action to manage risks and drive improvement. For example, one person experienced a number of falls and no action had been taken to consider a referral to the falls team or consider the use of assistive technology to reduce the risks to the person. Not all incidents were recorded. Only accidents were recorded which meant that incidents such as those between people were not suitably recorded and analysed.

There were no systems in place to monitor allegations of abuse in the home and to ensure that appropriate action was taken or that referrals were made to external bodies responsible for investigating allegations of abuse. The provider did not have effective systems to provide oversight of the quality and safety of people's care. We found significant shortfalls in people's care, the maintenance of the home and knowledge of the registered manager however; the provider had not deployed systems to identify these or take appropriate action. We saw that the provider had completed audits of the home environment. However, these were ineffective and did not suitably identify concerns. For example, an audit was completed of "Individual accommodation: furniture and fittings" which looked at people's individual bedrooms. This identified that lockable storage was available for medication, money and valuables. We found this was not the case and that people's prescribed topical medicines were not kept securely and were accessible to anyone, including

vulnerable people in home. This showed that audits were ineffective in identifying concerns and driving improvements.

The above evidence demonstrates that systems and process were not established or operated effectively to ensure that people received a good quality and safe service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post which is a requirement of the provider's registration with us. However, they were unaware of all their responsibilities of registration. We found that an incident of potential abuse had occurred at the home and this was recorded in a person's daily notes. We had not been notified of this event. This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009 (Part 2).

The registered manager could not demonstrate an understanding of their responsibilities in relation to duty of candour. A person who used the service had suffered abuse whilst living at the service. They had not received an apology or written information about investigations that had taken place and details of further enquiries into the incident.

This was a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed to the way people and staff were involved and engaged in the development of the service. The registered manager told us that a feedback questionnaire was in the process of being sent out to people who the service, however this had not yet taken place. We saw that one residents meeting had occurred, however relatives or representatives were not invited into the service to support people to share their views. Despite what we found, people and relatives felt that they could offer feedback to staff and the registered manager and that this would be listened to. A relative said, "I've not been formally asked for feedback but they do listen."

People, relatives and staff felt that the registered manager was approachable and supportive. A staff member said, "I do feel supported in my role by the manager." People and relatives felt there was a friendly and homely atmosphere and that they would be listened to should they have any issues to raise.

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 11 HSCA RA Regulations 2014 Need for consent People were not always supported to consent to their care. When people lacked mental capacity to make certain decisions, the Mental Capacity Act 2005 was not followed correctly to ensure their legal and human rights were protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour A person who used the service had suffered abuse whilst living at the service. They had not received an apology or written information about investigations that had taken place and details of further enquiries into the incident.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not assured themselves that staff were suitably qualified, skilled and competent.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We found that an incident of potential abuse had occurred at the home and this was recorded in a person's daily notes. We had not been notified of this event.

The enforcement action we took:

We imposed a condition on the provider's registration to say they must put in place a system to review all records of accidents/incidents and allegations of abuse and ensure that action is taken to mitigate the risk of accidents/incidents or allegations of abuse reoccurring within the home. This system must also ensure that all notifications are made to the relevant external bodies as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care because their risks were not always suitably assessed and minimised. People's medicines were not always managed safely.

The enforcement action we took:

We took urgent enforcement to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from avoidable harm and abuse because incidents of potential abuse were not always investigated and/or reported to the local authority safeguarding team.

The enforcement action we took:

We took urgent enforcement action to impose a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance Systems and process were not established or operated effectively to ensure that people received a good quality and safe service.

The enforcement action we took:

We took urgent enforcement action to impose conditions on the provider's registration to say they must deploy a system to ensure independent scrutiny of the action taken by the registered manager and provider to monitor and improve the quality and safety of care provided to people. They must report to us about this monthly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment procedures were not always followed to ensure that staff and volunteers were safe and suitable to work with vulnerable people who used the service.

The enforcement action we took:

We took urgent enforcement action to impose a condition on the provider's registration.