

St. Mary's (Dover) Limited

St Mary's

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We undertook an unannounced inspection of this service on 10 and 11 February 2016.

St. Mary's is a large detached property providing residential and dementia care for up to 36 older people. The service is located within the town of Dover. Residential accommodation is situated over four floors. There is a separate unit to support people living with dementia. The service also has its own chapel and a well maintained garden to the rear of the property.

This service had a registered manager in post. A registered manager is a person who is 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 the time of inspection there were 23 people living at the service.

The premises was in need of repair and redecoration, and in some areas required action to be taken immediately to ensure that people were safe living at the service. Thermostatic valves or a system to regulate the water temperature was not in place to reduce the risk of scalding, and the electrical wiring safety certificate had expired. It was also identified on the previous legionella test in October 2015 that there was an issue with the water, which had not been monitored or risk assessed. There were two electric pumps in the garden to manage waste water and these had stopped working. Some windows had been repaired but there were others which could not be opened.

Equipment to support people with their mobility had been serviced to ensure that it was safe to use, and plans were in place in the event of an emergency. However, staff had identified that people required access to an additional hoist. The provider was requested to purchase a new hoist, but this request had not been actioned at the time of the inspection.

The majority of these issues had been highlighted in the quality assurance checks made by the registered manager, but the provider had not acted in a timely manner to improve the service, and make sure the premises were safe for people to live in.

Although people's rooms were checked to look for health and safety issues, there were no environmental risk assessments in place to make sure all areas of the service were as safe as possible. There was an uneven floor on the third floor in need of repair, and there was no risk assessment in place to ensure staff and people were aware of this hazard.

The first floor shower room was leaking and was out of action, together with the first floor bathroom, as the bath seat had broken.

Checks on the fire system had been made on a regular basis and fire drills had been completed, but staff attending these drills had not been recorded to ensure that all staff were included, to ensure they had a clear understanding of what action to take in the event of a fire.

Accidents and incidents were recorded and appropriate action had been taken to look for patterns or trends, to prevent further occurrences.

There were not always enough staff deployed to ensure that people received care and support in an effective and timely manner. People told us they had to wait for staff to respond to their call bells.

Recruitment processes did not fully meet the requirements of the regulations because prospective staff's conduct at their previous employment had not been verified, and there were gaps in employment histories, which had not been discussed.

Staff told us that they were provided with training but records showed updates of training were overdue for some staff. This could place people at risk of experiencing support that was not current or best practice. The registered manager had carried out an audit of the training required to ensure that staff received the relevant training, and was in the process of arranging for the shortfalls to be addressed.

Staff received individual supervision and an annual appraisal to address training and development needs.

Not all staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), so some staff were not fully aware of the process to support people, who may lack capacity, to make decisions about their care.

We observed the medicines administration and found that medicines were not being recorded or given to people safely. The storage of the medicines also needed to be improved.

Staff listened to what people asked them and responded appropriately. People were not always treated with dignity and respect when staff were completing documentation, and supporting them to eat their meals.

Records, such as the medicine records and food and fluid charts, were not accurate and completed consistently.

People had individual risk assessments with regard to their care and behaviour. Risk assessments to move people safely were detailed to ensure staff had the guidance to move them safely. Assessments were also in place to support people with their behaviour, but in some cases specific details were required to list any known triggers to minimise their future occurrence.

Although there were some activities in the dementia unit, on the day of the inspection, there were no activities in the residential lounge. Although people's preferred hobbies and pastimes were recorded in their care plans there was no evidence to show that staff were supporting them to participate in the activities of their choice.

Staff understood how to protect people from the risk of abuse. Safeguarding training was ongoing and in addition, staff had one to one supervision with their line manager so that they were aware how to report any concerns in order to keep people safe. Staff were confident to whistle-blow to the registered manager if they had any concerns, and were confident that appropriate action would then be taken.

People, who were able, were involved in planning their care and others were supported by their family. Care plans included people's preferred routines, their wishes, preferences and skills and abilities. There were review meetings to discuss people's current support and make any necessary changes in their care.

People were supported to access health care appointments and staff monitored their weights and general health, involving relevant health professionals as required. Staff were familiar with people's likes and dislikes and supported them with their daily routines. People had access to the food that they enjoyed and their nutrition and hydration needs had been assessed and recorded.

Records showed that the registered manager had investigated formal written complaints and responded to the issues raised. However, some people told us that the staff had not responded when they complained that they had to wait a long time for the call bells to be answered.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?

Inadequate ●

The home was not always safe.

The premises were not being well managed to make sure it was safe. Some required safety measures were not in place, repairs were not being made in a timely manner and the electrical safety test certificate had expired.

There were not always enough staff deployed in the home to meet people's care and support needs.

Staff records did not show that robust recruitment procedures had been followed to ensure staff were safe to work at the service.

People's medicines were not well managed and recorded.

Staff understood the process of how to report and action allegations of abuse to protect people from harm.

Is the service effective?

Requires Improvement ●

The home was not always effective.

Some staff had not received Deprivation of Liberty Safeguards and Mental Capacity Act training and were not fully aware of the process to ensure that people were supported to make decisions in their best interests.

Staff had not received sufficient training to ensure they had updates with current care practice to effectively support people. Staff received individual supervision and an annual appraisal to address training and development needs.

People were supported to maintain good health and had access to health care professionals when needed.

The service provided a variety of food and drinks to ensure people remained as healthy as possible.

Is the service caring?

Requires Improvement ●

The home was not always caring.

People were not always treated with respect and dignity when staff sat down beside them to complete documentation and in some cases when they were being supported them to eat their meals.

People told us that the staff were kind and caring.

Staff treated people as individuals, recognising their preferences and likes and dislikes.

Care records, and information about people, was treated confidentially.

Is the service responsive?

The home was not always responsive.

People and relatives told us that although some activities were being provided, people were not being supported to maintain their hobbies and interests.

People told us that the staff had not responded to their complaints that the call bells had not always been answered promptly.

People were involved in planning their care and the care plans were personalised to reflect their wishes and preferences. The care plans were also regularly reviewed and updated to reflect people's current needs.

People's and relatives views were gathered through reviews and resident and relatives meetings.

Formal complaints had been investigated and resolved, and then responded to appropriately.

Requires Improvement ●

Is the service well-led?

The home was not well led.

Checks and audits had identified shortfalls found during this inspection, however, the provider had not responded to address these issues in a timely manner.

Although there were systems in place to gather feedback about the service, there had been no quality assurance surveys sent to people, relatives, staff and health care professionals to give them

Requires Improvement ●

the opportunity to voice their opinion of the service.

Staff understood the visions and values of the service and told us the registered manager and senior staff were approachable, supportive and helpful.

St Mary's

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.

We undertook an unannounced inspection of this service on 10 and 11 February 2016. We spent some time talking with people in the service and staff; we looked at records as well as operational processes. The inspection was undertaken by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority. On this occasion the provider had not received 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 gathered and reviewed information about the service before the inspection, including notifications. A notification is information about important events, which the provider is required to tell us about by law.

We reviewed a range of records. This included eight care plans and associated risk information and environmental risk information. We looked at recruitment information for five staff, including one who was more recently appointed; their training and supervision records, in addition to the training record for the whole staff team. We viewed records of accidents/incidents, complaints information and records of some equipment, servicing information and maintenance records. We also viewed policies and procedures, medicine records and quality monitoring audits undertaken by the registered manager and provider. We spoke with ten people, four relatives, eight staff, the registered manager, deputy manager, team leader and provider.

We last inspected this service on 21 April 2014 when no concerns were identified.

Is the service safe?

Our findings

People told us they felt safe living at the service. They said: "Yes I feel safe here". "Since coming to live here I have been very spoilt and I cannot fault the home. I feel completely safe and the food is excellent".

A relative commented: "A carer had noted some bruises on my relative and so they have mapped them. I am sure there is nothing untoward going on here and I certainly would not suspect any abuse".

Although people told us they felt safe, we found examples of unsafe practices in the maintenance of the premises, medicine management, staffing levels, recruitment of staff and concerns about checks on the electrical system and control of hot water temperatures, all of which placed people at risk of harm.

People said that the premises could do with some repairs and refurbishment. A relative said: "The home is very 'tatty' and could do with some re-decoration". Staff also told us that they felt significant work was needed to be carried out to ensure the premises were safe.

Providers are required to ensure that the premises, and any equipment used are safe. We found hot water temperature checks were carried out regularly and records showed the temperature ranged from 45 degrees to 46 degrees. No action was being taken to reduce the temperature in line with the recommended temperature of 43degrees. (Particularly temperatures over 43°C can create a scalding risk to people). Each person had a wash hand basin in their bedroom; the provider could not confirm that thermostatic restrictor valves were fitted to the sinks. This meant the hot water supply to bedrooms, to which people had unsupervised access, was not monitored or thermostatically controlled. This presented a serious risk of scalding. In addition, the test certificate to certify that the electrical wiring in the home was safe had lapsed in August 2015. The provider told us that he was in the process of getting a quote to do this work from a local electrician and would confirm to CQC when this work would commence.

There were two pumps in the garden which had stopped working. These pumps were used to ensure that waste water was pumped appropriately away from the building. These had been out of action since 27/01/2016. After the inspection the registered manager implemented a detailed risk assessment, including the measures to be taken in the event of an emergency. The provider told us that they would arrange for these to be repaired on Monday 15 February 2016; however contact was not made with CQC to confirm what arrangements had been made to address these issues.

The legionella test of the water took place in October 2015, when it was advised that the test was clear but there was another issue with the water. This had not been monitored or risk assessed to ensure a safe practice was in place. There were no timescales and measures in place to check the system to reduce the risks. After the inspection the registered manager told us that a new legionella test was being carried out on 17 February 2016.

Some repairs had been completed to ensure some windows were in good order, but other windows would not open at the time of the inspection. The registered manager stated they had requested the handyman to

check all of the windows, carry out the necessary repairs and implemented a risk assessment with control measure to reduce the risks but this had not yet happened.

The first floor shower room was leaking and was out of action together with the first floor bathroom as the bath seat had broken. The registered manager told us that the provider had a quote to replace the chair but there was no timescale as to when this was to be replaced. The shower room had been identified on the environmental risk assessment, to be repaired within 12 months.

The service employed a full-time maintenance person who was seen to be repairing day to day issues in the service, as well as completing some painting in the corridors. Staff, people and relatives were positive about recent improvements to the premises, such as the reception area, and replacement of worn carpets, with laminate flooring in some areas. However, the quality of furnishings, fittings and decoration in the many communal areas and bedrooms, was in need of attention. Wallpaper had tears, windows did not open, doors and skirting were scuffed and furnishings appeared old and worn. People were at risk of harm from environmental hazards such as frayed carpets and uneven floorboards. There was no risk assessment in place to ensure people and staff were aware of these hazards and to reduce the risks of people or staff tripping or falling. After the inspection the registered manager sent CQC a copy of a risk assessment that she had written.

The provider had not acted in a timely manner to ensure the premises were as safe as possible. The provider had not acted on identified findings to ensure that people were adequately protected against the risks of scalding and not ensured the electrical system was tested and certified as fit and safe to use. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of harm as they were not always receiving their prescribed medication. We assessed the procedures for the ordering, receipt, storage, administration, recording and disposal of medicines. The service used a medicine dosage system for most of the medication which was delivered by the local pharmacy. A number of prescribed tablets had not been dispensed, even though the medicine records had been signed to indicate that they had been given. Staff did not have an explanation as to why this had happened, and there was not always information recorded on the back of the medicine record to confirm why the person had not taken their medicines. In addition some medicine records had gaps where there was no signature at all, so we could not be certain if people were receiving their medicines correctly.

In the dementia unit two of the medicine records only had photographs of the person, and no name or room number recorded, therefore people's identify was not clearly recorded. We noted that the code 'S' was being used and staff told us this was when people were asleep and did not take their medicine. There was no indication to show that staff returned to give the person their medicine later, or what action they should take if the person was consistently sleeping at that time, and not taking their medicines, for example, asking the doctor if the medicine could be taken at a different time. Staff told us that the outcome should have been recorded on the back of the medicine sheet, but no information had been recorded.

One person's medicine record noted that their medicine was not available from 01/02/2016 to 10/02/2016. There was a note on the back of the medicine record which stated that on 4/02/2016 'request for more - faxed to the surgery', but the medicine had still not been received, so the person had not been given their prescribed medicine.

Staff told us that the medicine round could take over two hours to complete. This could have an effect of people not receiving their medicines within the required administration times. At 11.40 a senior member of staff told us that she needed the medicine records as one person had not had their 8.00 medicines yet, and

she was going to see whether they would take them now. We checked the medicine sheet and this had been recorded but there was no indication if taking the medicines late would have any detrimental effects. We therefore could not be assured that people were receiving their medicines as instructed by their doctor.

Some people had additional 'medicine countdown sheets' recording 'as and when required' medicines, which were used to manage the stock correctly. We checked some of these figures and found that one person's records stated on 23/11/15, there was 175 Paracetamol soluble 500mg tablets recorded, none had been administered, but there were actually 265 in stock. Another person's sheet had counting errors, which demonstrated that the medicines had not been checked thoroughly when it was being completed. Staff told us that the countdown sheets had been audited, but did not know why the figures did not match.

Storage temperatures, including cold storage, had not been recorded consistently, for example staff were required to record the fridge temperature in the morning and afternoon, but this had only been done, 12 times in January and 4 times up to 10 February 2016. The other storage temperatures were in some cases not recorded, and when the temperature was over the recommended temperature, there was a column on the form which was for staff to complete with 'Action taken if near or above 25 degrees', which had not been completed. This did not ensure the medicine was stored at the correct temperature and remained fit for use.

Staff were not ensuring that people received their medicines safely and in line with the prescriber's instructions. Medicines were not being monitored to ensure they were stored at the correct temperatures to ensure they were fit for purpose. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of the inspection the registered manager had addressed some of the medication issues outlined in this report. There was a meeting with senior staff to discuss the importance of people receiving medicines as per the prescribed dosage; accurate recording and observations to ensure staff had the competencies to give people their medicines safely. Weekly and monthly audits had been implemented, as well as competency checks for the staff.

Staff ensured that the trolleys were locked and secure. Medicines with a required shelf life had been dated when opened to ensure people received the medicines safely. Records showed that people who required a transdermal patch application had body maps in place, which documented when it was changed, and where on the body a new patch had been placed. It showed clearly that it was always applied to a different area of her body to reduce the risk of damage to skin integrity. There was a pain chart in people's care plans, and information on how people may act if they were in pain, such as staff to monitor body language and facial expressions, so that pain relief could be offered.

There were currently no controlled drugs held at the service, however there was appropriate storage and an appropriate controlled drug register in place for when they did have a service user who was prescribed controlled drugs. Staff who handled medicines had completed training and had received observational assessment of their competency to administer medicines safely.

The registered manager told us that staffing levels were assessed to the needs of the people living at the service. Some people said they had to wait for staff to respond to them when they rang the bell, and we observed that for over an hour and a half no member of staff checked the people were safe in the first floor lounge. Some people felt staffing levels were satisfactory, whilst others felt more staff should be on duty. One person said: "No, sometimes there isn't enough staff on duty".

During this inspection, two relatives and two people told us that, at times, there were not enough staff on duty. This meant that people sitting in one of the lounges were not adequately supervised and response to call bells was sometimes slow. One person reported that they had fallen and had not been found by staff for over an hour later. The registered manager was in the process of investigating this matter.

Last November concerns had been made to CQC that included a concern about lack of staffing during the day and at night. The registered manager's response to CQC indicated that there had been a reduction in people to 24 living at the service, therefore day time staffing levels were six or seven care staff, and three or four at night. The staffing rota indicated that staffing levels were generally in line or in excess of this, although there were times when day time staffing levels fell to four carers. There were now 23 people living at the service and the registered manager told us that there should be a minimum of six care staff in the morning, four during the afternoon and three waking night staff. However between the hours of 2pm to 4pm only four members of staff were on duty. There were three people in the dementia unit who needed more than one member of staff and the use of a hoist to support them, and four in the residential unit. Therefore at times, if two people wanted to use the bathroom at the same time, there would be no staff available for the other people living at the service.

Staff told us that on occasions they had to ask people to wait as the stand aid hoist would be in use in the other unit.

The provider must ensure that they deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure they can meet people's needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have safe recruitment systems in place. We reviewed the files of five members of staff and found that new staff routinely started work in the service prior to police check clearances being completed or satisfactory proof of previous conduct from their last employer. These checks were required to validate that new staff had proof of identity and they were suitable to work with people at risk. Inconsistencies and gaps in employment history were not investigated and explained, referee details did not match those given by applicants on the application form, and references were not confirmed.

There had been no new recruits in the last six months to assess the training and induction programme. Staff spoken with told us they had completed an induction and shadowed staff until they were confident to work on their own, however there were no records of induction undertaken by staff in two of the files seen. Files did contain health declarations to ensure staff were fit to work in the service. The manager had undertaken a review of staff files and reported that steps had been taken to ensure that all new recruitment would be in line with safe practice.

The provider had not ensured that all the information was available as required in the regulations before new members of staff started work. This was a breach of Schedule 3 of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with people's care and support had been assessed and procedures were in place to keep people safe. There were clear guidelines in place to manage risks when supporting people with their mobility, which included people's medical conditions. However, although there were seven people who required to be supported with a hoist, only one person had their own sling. Each person should have their own sling to ensure it is the correct fitting and to reduce the risk of infection.

In some cases the risks to support people with their behaviour required additional information to ensure

staff would be able to recognise any triggers before the behaviour occurred. One person in the dementia unit said on several occasions that she wanted to go home and had put their coat on. Staff did try to reassure the person but this did not work fully as the person became more anxious. There was no full guidance in place to show staff how to reduce the person's anxiety. Staff told us how people sometimes just needed reassurance by holding their hands and speaking with them quietly. They told us the assessments could be more specific to each person so that staff had the same consistent approach to calm and reassure people.

Domestic staff were cleaning the home throughout the inspection. Carpeting and one section of stairs were stained and in need of cleaning. The registered manager reported that a programme of cleaning the carpets was underway. People told us the service was clean. They said: "They (the staff) keep our rooms nice and the basins and toilets are always clean. However, the communal lounge is not always clean". It was also noted that the little tables in the lounge were sticky and a relative said "I sometimes bring in a cloth to wipe the tables as there is often dried food on them". We discussed this issue with the registered manager who told us that they would be monitoring that the tables and lounge area was clean and checks would be put in place to ensure the staff responsible were completing these tasks.

Staff were aware of how to protect people and the action to take if they had any suspicion of abuse. They were able to tell us about the signs of abuse and what they would do if they had any concerns, such as contacting the registered manager or local authority. The service had a copy of the local authority's multi-agency safeguarding vulnerable adult's policy, protocols and guidance. This policy is in place for all care providers within the Kent and Medway area and provides guidance to staff and to managers about their responsibilities for reporting abuse.

People were protected from financial abuse. People's monies and what they spent were monitored and accounted for. Only the registered manager and deputy manager had access to people's finances and these were checked regularly to ensure they were accurate and in good order.

All staff were undergoing refresher safeguarding training and this was being supported by individual safeguarding supervision sessions with their manager, which covered relevant policies and procedures. Staff spoken with during the inspection were aware of how to respond to any concerns or allegations of abuse and were confident in how to escalate any concerns appropriately. Staff were aware of the whistle blowing policy and spoke confidently about reporting any concerns they may have to the registered manager and other external agencies, such as the local authority. Staff said: "I feel confident to say what I see and would inform the registered manager if I had any concerns".

Checks had been carried out on the premises, such as the gas safety certificate; portable electrical appliances, fire alarm and fire fighting equipment were checked when needed to keep people safe. Tests and checks of the fire alarm system were carried out regularly, to ensure equipment was in working order. Records indicated that the home undertook appropriate regular testing of fire systems, emergency lighting and equipment, and that staff had training on fire and safety procedures. However, fire drills records did not show which staff were involved to ensure that every member of staff, including the night staff, completed the drill so that they were familiar with actions in the event of an emergency. Staff were provided with information about actions to take in an emergency and had emergency numbers to call. Individual plans detailed the support people required to evacuate the building safely.

Accidents and incidents were recorded, investigated, and appropriate action was taken to reduce the risks of them happening again. The events were analysed to look for patterns and trends to reduce the likelihood of reoccurrence. Records showed that when a person had fallen three times their medicines were reviewed

and no further incidents occurred.

Is the service effective?

Our findings

People told us that their health care needs were met. Relatives commented: "One thing I cannot fault them for is their communication regarding my relative's health. I am notified immediately of any change in her condition or of any falls that they have". "The staff appear to know how to look after the people here". "The staff say they are having a lot of training for their vocational care qualifications which I think is a good thing".

The registered manager had carried out a review of staff training in December 2015, and was using this review to drive progress on training across the staff team. The audit had identified a lack of progress on completion of workbook training as well as gaps and areas for development, for example, lack of evidence of induction training for new staff. The registered manager told us that the induction training programme was in the process of being reviewed and they would be implementing new the Care Certificate which has been introduced nationally to help new care staff develop their skills, knowledge values and behaviours.

Not all staff had completed the workbooks which covered the mandatory training such as health and safety, moving and handling, infection control, food hygiene and fire awareness. The registered manager acknowledged that this was an area for improvement and had an action plan in place to address the shortfalls.

Seventeen staff had completed vocational qualifications in health and social care and a further nine were in the process of completing the diploma. These are work based awards that are achieved through assessment and training. To achieve vocational qualification candidates must prove that they have the competence to carry out their job to the required standard.

Staff regularly met with their manager for supervision and annual appraisals to discuss their personal development needs, and any areas where they could benefit from further training. Staff meetings were also held to give them an opportunity to discuss the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions, and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and be as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. There were two people who had a DoLS authorisation in place. The registered manager advised us that they were also applying for DoLS authorisations for some people but the applications had not been processed at the time of the inspection.

Staff were aware of the need to involve relevant people if someone was unable to make a decision for

themselves, however, some staff lacked an understanding of the process to ensure that people were supported to make decisions in their best interests. They were not aware who was under a DoLs authorisation, therefore we could not be sure that the recommendations made by the authorisations were being consistently followed. This is an area for improvement. The registered manager and senior staff were fully aware of the restrictions and these were recorded in the care plans.

Before people received any care or treatment they were asked for their consent. People or their family had signed to agree with their care plan, including taking photographs and taking their medicines.

People's health care needs were met. One person said: "The District Nurse comes regularly to dress my legs". We observed senior staff arranging for medicines to be delivered, doctors to be called and making appointment with other health care professionals. Care records showed that people regularly saw the chiropodist, dentist, optician and attended out patient's appointments when required. Where people had specific medical conditions, such as diabetes, this was monitored through their care plans. Although staff were able to describe what symptoms and actions they would take if people living with diabetes needed medical attention this was not recorded in people's individual care plans. This was an area for improvement.

People were very complimentary about the food saying "It's really enjoyable and we have plenty to eat, including a snack of fresh fruit brought to us in the afternoon". "I am diabetic and the chef is very mindful of this and ensures that anything I have is suitable for my condition". "I am a fussy eater and the chef is very good and does special things for me". People told us that they could request a cooked breakfast, and there were two main choices at lunch time and a buffet type tea where residents could choose items from the trolley.

People were encouraged to eat in the dining room but some chose to eat in the lounge or in their rooms. People who chose to eat in the dining room appeared to enjoy their time together and said "It's nice to have a chat at meal times". We observed the meal being served, which looked appetising and inviting. Most of the people in the dining room could manage on their own, but one person was being supported to eat their meal. The member of staff was smiling, chatting to the person and encouraging them to use the cutlery, whilst also supporting them, when they needed a little more assistance.

Staff were very aware of people's likes and dislikes and told us meals were adapted to suit these preferences. People's weight was monitored and a healthy diet encouraged. Health professionals, such as dieticians had been involved in the assessment of some people's nutritional needs. Recommendations they had made about the softened consistency of their food had been followed through to ensure people received their meals in line with their dietary needs. The chef was very familiar with people's different diets and ensured that people had a varied menu to choose from. They talked about how they fortified meals for people if they required supplements to their diet, such as using cream in soups and full fat milk. Various drinks were available to people throughout the inspection and staff made sure that people had the fluids they needed. We observed people being offered regular drinks and snacks, such as biscuits.

Is the service caring?

Our findings

People said the staff were kind and caring. They said: "This is a very caring home". "The staff know, and understand me". "I like the management staff; I have warm and friendly chats with them". A relative said: "I cannot fault the care or the carers. The care they give is genuine".

Staff told us that the care was good and said: "The staff do well to make sure people receive the care they need".

Most of the time people were treated with respect and staff were kind and caring. However, during our observations, there were a couple of occasions when staff were not as considerate as they could be. For example in the dementia unit, a staff member sat down next to a person who was looking upwards holding a beaker to their mouth. The staff member did not speak to the person or acknowledge them, they just started to complete paperwork. They did not notice that the person was falling asleep still holding the beaker to their mouth. On another occasion the staff did not notice one person was wiping her nose on the bottom of their blouse.

In the dementia unit there were three people being supported to eat by members of staff and one person was being helped by their relative. The three people being supported to eat were in armchairs and everyone else was sat at the dining table. There was some talking but generally very little interaction between staff and the people they were supporting. One person was trying to talk a lot when he was eating and was not always getting a response from the staff member. Ensuring that staff fully interact and engage with people in a meaningful way is an area for improvement. .

One member of staff was patient and kind when they were asking a person what they wanted for their lunch. The person said they did not want either choice on the lunch menu. They asked for a sandwich instead of lunch. Staff asked what they would like in the sandwich and they choose egg mayonnaise. Staff then asked the person if they preferred to have their dinner at supper time, but they declined the offer.

People and their relatives had been involved in talking about and recording their life histories in their care plans, so that staff knew what was important to them. Two relatives told us they had read and signed their relatives care plan on their behalf. People's rooms were personalised to their own taste and they had their personal photographs and possessions in place.

People were able to choose where they wanted to spend time in the communal areas or time in the privacy of their bedroom. They were called by their preferred name, which was recorded in their care plan. They were also asked if they preferred a male or female member of staff to support them with their personal care. Two people told us that they preferred to have female staff and their decision was respected.

A person who recently celebrated their birthday said: "They made a room available for all my family to come and we had "posh fish and chips" together and the chef made me a lovely cake".

Visitors were welcome in the service and there were no restrictions as to when they could call. Relatives told us they were welcomed when they visited and were offered refreshments.

Staff ensured people's privacy was maintained, by carrying out personal care discreetly in their rooms. Staff knocked on doors and waited for a response before going in, showing they recognised and respected people's private space. Staff told us how they made sure curtains and doors were shut and they covered people when they were supporting people with their personal care. People were addressed by their chosen name and told us they got up and went to bed at the times they wished.

People's religious beliefs were supported. The service had developed links with local church groups and regular church services were held in the chapel on the ground floor of the service. People were seen using the chapel when they wanted.

People who needed support to make decisions about their care could be supported by the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

People's personal information was stored safely. Records were locked away and staff looked at them when they needed to.

Is the service responsive?

Our findings

People told us they received the care they needed. However, they said they had complained to staff about the time it took for them to answer the calls bells. In the first floor lounge visitors were concerned that staff had not come into the lounge for over one and half hours, especially as the only means of communication was one bell situated near one of the doors. One person told us that if anyone needed staff or fell they would get up and ring the bell. We discussed this with the registered manager who said that they would look at the deployment and allocation of staff to this area at the beginning of each shift to address this issue.

People told us that they did otherwise feel that staff kept them safe and they could rely on the staff to come into the lounge just before lunch to ask them if they needed the bathroom and help to go to the dining room. A relative commented: "There really needs to be more supervision of the residents in the lounge".

One person said: "They (the staff) are a very long time answering the bell and I have told the senior carer this, but again this week I fell out of bed and only reached the bell with difficulty. They were a long time coming to answer it". The registered manager was aware of this incident and was in the process of investigating the call bell records to ascertain how long it was before staff became aware of the situation.

There had not been any new admissions at the time of the inspection; however systems were in place for pre-admission assessments to be completed to ensure that the service was able to meet people's individual needs and wishes. Care plans would then be developed from discussions with people, and from the information in the assessments.

People's preferences of how they received their personal care were personalised to their wishes, such as what toiletries they preferred, including bubble bath and talc. The plans showed what people could do for themselves and what they needed staff to support them with, for example one care plan stated that the person could bathe themselves but needed staff to help wash their back. Other examples were if a person was not able to sleep offer them a drink and a light snack and it was also noted that some people liked to have their bedroom door closed. Some people or their relatives had signed documents within their care plans as confirmation that they agreed with the content. The care plans had been regularly reviewed and updated to ensure that staff had up to date information of each person's current care needs.

People told us that they were able to have a bath once a week or more if they wished to. The shower room was out of action and the provider told us that no one had requested to have a shower, but the repairs would be considered so that people could be given the option. Some people we spoke with did not realise a shower was an option. One person said: "I only have a full body wash down".

Care plans to support people with their behaviour were in place, which showed that staff had monitored people's behaviour, it described what the person may do and what measures could be taken to reduce people's anxiety such as taking the person for walk in the garden, and reminiscing. The plans also detailed health care professional involvement should the need arise for further action or guidance. However, other behavioural assessments were not as detailed with individual's specific behaviour to ensure staff had the

information to reduce their anxiety.

People's skin was monitored to ensure it remained as healthy as possible, and equipment, such as special cushions or mattresses were in place to reduce the risk of people developing pressure areas. People at risk of falling had equipment in place to reduce the risk, such as pressure mats to alert staff they were out of bed and may need support.

People had some opportunity to provide feedback about the service provided; there were resident and relatives meetings. These were held regularly with minutes taken to action any ideas or suggestions.

There were some activities in the dementia unit during the morning. The lounge was busy as relatives were visiting and people were completing large jigsaw puzzles and dancing, however when relatives left the unit staff did not always ensure that they interacted with people to support them to be involved in other daily activities. We observed that people dozed off while others looked around the unit with nothing to occupy them. After discussion with the registered manager they spoke with staff in the unit and activities were observed happening during the afternoon. The service had appointed an activities organiser who was off sick at the time of the inspection.

Care plans had details of what individual people liked to do and their previous hobbies, for example in one plan it stated that the person liked helping staff clean their room and folding washing, and did not like being bored and having nothing to do. This person was part of our observations and when they became distressed and said they wanted to go home, staff did not engage them in these activities, which may have helped to reduce their anxiety.

There were no activities observed for people sitting in the first floor lounge. There were no newspapers or magazines and no activities going on. One person said: "When I was living at home I spent a lot of time on the computer which I miss very much. However, I am quite happy here and they are good to me. Sometimes a group of us do a jigsaw puzzle together, which is rather nice". Another person said they used to do a lot of knitting and artwork before coming to the service. One relative commented: "My relative gets very agitated if left on her own. If only the carers were more visible in the lounge and spent time chatting to the residents or engaging them in some activity". "There is a list of activities on the wall, but nothing seemed to be going on". The registered manager told us that activities had been discussed at the 'residents meeting' and they were introducing "Interactive Me", an electronic system for tablets and laptops with music, shows, photos and recordings personalised to individual older people to help stimulate positive memories and entertain.

Several people said they enjoyed going into the garden in the summer. The garden was enclosed with tables and chairs for people to sit and look at the chickens, which were looked after by the staff. Staff told us that the activities could be improved and talked about how people responded to being occupied and how they liked passing their time being involved in daily life. Engaging people in meaningful pastimes and activities they enjoy is an area for improvement.

There were systems in place to ensure that any complaints were responded to appropriately. Staff felt confident to pass complaints they received to the registered manager or senior members of staff. Records showed that the registered manager had investigated formal written complaints and responded to the issues. However, some people told us that the staff had not responded when they complained that they had to wait a long time for the call bells to be responded to.

At the 'residents meeting' it was raised that laundry items were going missing and although this had been reported it seemed an ongoing problem. We noted that in the staff meeting in June 2015 the provider told

staff that a laundry person would be appointed but at the time of the inspection care staff were completing laundry tasks and a dedicated laundry person had not been appointed. The registered manager told us that these issues would be addressed.

Is the service well-led?

Our findings

At the time of the inspection we noted that there were concerns about the support from the provider to run the service efficiently. The registered manager was restricted and unable to manage with autonomy due to the systems that had been implemented by the provider. The registered manager was not able to authorise repairs or purchase items for the service without prior authorisation from the provider.

A relative said "The manager is very new here and is trying her best to make some improvements. I feel there is constraint because of finance which is a shame; as if the building was updated they would get more residents to fill the empty beds". Another relative told us that they had spoken with the provider and told them that the premises were in need of repair.

Staff told us that the décor of the premises needed to be improved. They said people visiting had noticed that it was in need of repair.

The provider visited the service each week and was made aware of the shortfalls noted in this report but had not responded in a timely manner to authorise the repairs to the pumps, the implementation of systems to reduce the risks of scalding, the treatment of the water with regard to the risk of legionella and the action to be taken to address the out of date electrical hard wire testing certificate. The provider had not ensured that the premises were as safe as possible for people living at the service.

We asked the provider to advise CQC in writing by Monday 15 February, 2016, when the above shortfalls would be addressed, but no response was received by that date to confirm what actions had been taken to ensure people were safe.

Staff told us that it took a long time for the provider to respond to their requests such as when they highlighted that the service needed an additional hoist. It was noted that this had been discussed at the staff meeting in August 2015. The service had two 'stand aid hoists' but one was not working. Staff highlighted the conflict it caused between the availability of the equipment and the welfare of the people. The provider advised staff that he would contact the company who was supposed to fix this. At the time of the inspection there was only one 'stand aid' hoist available as the provider had not acted on this request.

The registered provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that there was a system in place to obtain information about the quality of the service and to make any improvements based on the information, but there was no record available at the time of the inspection to confirm when the last quality assurance survey had taken place. Therefore people, their relatives/carers or visiting professionals, including authorities who paid for people's care, were not asked for their views of the service.

Records were not always completed fully or accurately. Some medicine records had gaps where staff had not signed to confirm they had given people their medicines or records had been signed when the tablets were left in the dosage system. Medicine sheets were not accurate when checks were done on the number of tablets in stock. Food and fluid charts had not been added up to show what quantity people had taken. Repositioning forms had not been signed to confirm people had been supported to change position regularly to keep their skin as healthy as possible.

The provider had failed to seek the views of people, their relatives/carers or visiting professionals, to voice their opinions on the service provided. Records were not completed properly or accurately. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had recognised the key challenges of the service and was taking action to manage these. The registered manager had been in post for six months and during that time had reviewed and implemented personalised care plans. They had carried out some detailed risk assessments on the service, which covered most of the issues raised in this report. The provider was aware of these findings and some of the areas of improvement had been completed, such as some repairs to the windows, fitting some more window restrictors and ensuring call bells were working. However, there remained substantial work to be carried out to address the repairs, maintenance and decoration of the premises to meet the regulations, and make sure people were living in a safe service. The registered manager had also completed an annual maintenance plan for the handyperson to work through, with timescales to be completed by 2017.

In addition audits had been carried out with regard to care plans, medicines and training. The shortfalls in the training had been identified and a system was being implemented to monitor the training needs and identify when staff needed refresher training. Training courses had already started to address the shortfalls so that all staff received the training they needed. The registered manager also took action on the second day of the inspection when we pointed out the shortfalls in medicines, and implemented risk assessments with regard to the repair of the pumps, the uneven flooring and arranged for a new legionella test on the water.

Staff handovers highlighted any changes in people's health and care needs. Staff were clear about their roles and responsibilities and the staffing structure ensured that they knew who they were accountable to. Staff understood their roles and responsibilities and told us that they felt supported by the registered manager and senior staff. Some staff told us how the service had improved since the current registered manager was appointed. They said they were confident to raise issues with the registered manager to discuss their practice and ask for guidance if needed.

Staff told us: "This is the best team that I've worked with. I get support on how to deal with residents if they are upset, we have very supportive managers". "I really enjoy working here". "The service has improved since the registered manager was appointed". "The care is good here, I would not work here if it wasn't",

Staff understood the visions and values of the service, by treating people as they would want to be treated themselves. They said they had a person centred approach, treated people with dignity and promoted their independence. Staff said: People should have total freedom of choice, this is their home, they don't live where I work, I work where they live". People should receive the highest level of care; we are like a family here".

The registered manager told us that the senior staff attended workshops to improve their practice, such as the district nurses forum.

Services that provide health and social care to people are required to inform us of important events that happen in the service. The registered manager had informed us of events in a timely way. We checked that appropriate action had been taken following any incidents, and it had.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services.</p> <p>The provider had failed to seek the views of people, their relatives/carers or visiting professionals, to voice their opinions on the service provided.</p> <p>Records were not completed properly or accurately.</p> <p>Regulation 17 (1)(2)(a)(b)(c)(e)(f)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>Recruitment procedures were not established and operated effectively to ensure that information was available in relation to each such employed person specified in Schedule 3. Regulation 19 (3)(a)</p>

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to mitigate risks in relation to proper and safe management of medicines, the premises and the health and safety of people

The enforcement action we took:

We served a warning notice