CareQuality Commission

CLS Care Services Limited

Elm House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on the 28 August, 3 September and 1 and 5 October 2015. The inspection was unannounced.

Elm House Residential Care Home is registered to provide accommodation for 40 people who require support and care with their daily lives. The home is located in the town of Nantwich close to shops, public transport and other local amenities. The premises provide purpose built accommodation in 38 single bedrooms and one double bedroom. It is a two storey building and people live on both floors. Communal facilities include bathrooms and WC's located around the home for convenient access. There are a number of lounges including a large sun lounge and dining area which overlooks the town centre and a hairdressing salon which is used by the visiting hairdresser. Access between floors is by a passenger lift or the stairs. The premises are set within pleasant gardens

Summary of findings

with an enclosed garden to the rear of the home. Car parking is available to the front and side of the building. On the first day of our inspection there were 31 people living in the home.

The home has 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.

When we carried out our last inspection of the home in July 2013 we found that the provider was meeting all the requirements for a service of this type.

Whilst we found that people were provided with care that was kind and compassionate, the home was not always being managed effectively. There were times when there were insufficient suitably qualified and competent staff on duty, to provide a safe service to the people who lived in the home.

We found that concerns and complaints raised by staff and visiting professionals had not always been responded to effectively, so management were not learning from past events, or taking effective corrective action to improve the service.

Although some people told us they felt safe, we found that management and staff had not always taken effective action to protect vulnerable people from abuse and neglect.

We identified breaches of the relevant regulations in respect of person-centred care, need for consent, safe care and treatment, safeguarding service users, good governance, and staffing. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People told us that they felt safe and staff we spoke with were aware of how to recognise and report signs of abuse and were confident that action would be taken to make sure people were safeguarded from abuse. However, management had not responded effectively when allegations of abuse had been made, medication and risks were not always managed effectively and there were occasions when there had been inadequate staff on duty.

Recruitment records demonstrated there were systems in place to help ensure staff employed at the home, were suitable to work with vulnerable people.

Requires improvement

Is the service effective?
The service was not consistently effective.

People told us that they were well cared for by staff who were knowledgeable and skilled. However, we found that staff were not always receiving adequate levels of support and supervision. The registered manager told us that they were responsible for the supervision of care team leaders but had not provided any since they started work at the home in May 2015

People were involved in planning their care to a certain extent but the provider did not always act in accordance with the Mental Capacity Act 2005 to ensure people received the right level of support with their decision making.

Requires improvement

Is the service caring?
The service was caring.

People were provided with care that was kind and compassionate.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Good

Is the service responsive?
The service was not always responsive.

Whilst people praised the staff and some reported receiving good standards of care we found examples where care had not always been provided in a person centred way.

Complaints had not always been investigated or responded to, or effective action taken to eradicate problems and prevent recurrence.

Requires improvement

Is the service well-led?
The service was not always well-led.

Requires improvement

Summary of findings

Systems and processes established to ensure compliance with the regulations were not always operated effectively so the health and well-being of the people who lived at the home was not assured.

People, who lived at the home told us that the registered manager was accessible, listened to them and involved them in decision making. A quality assurance survey completed in 2014 indicated that those who responded enjoyed a high degree of satisfaction with the standard of care and facilities and services provided.

Elm House Residential Care 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 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 carried out an unannounced inspection on the 28 August, and visited again announced on 3 September and 5 October 2015. We also carried out an unannounced visit at night time on 1 October 2015. The inspection was carried out by two adult social care inspectors and an expert by experience on the first day, an adult social care inspector and a pharmacist inspector on the second day and one adult social care inspector on the third and fourth days. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information the Care Quality Commission already held about the home. We contacted the local authority safeguarding and commissioning teams before and after the inspection and they shared their current knowledge about the home. During the inspection we spoke with 21of the people who lived at the home together with five of their visiting relatives. We talked with 16 members of staff including 13 members of the care staff team, the cook, the activities coordinator and the registered manager. We also spoke with two visiting doctors and two visiting nurses We looked at six life plans as well as other records and audit documents. We looked around the building including, with the permission of people who used the service, some bedrooms.

Requires improvement

Is the service safe?

Our findings

We observed relaxed and friendly relationships between the people living at Elm House Residential Care Home and the staff members working there. Staff were kind and caring in their approach and we saw that people were comfortable and at ease in the home's environment.

Most people spoke highly of the staff and the standard of care they received. In answer to our question as to whether they felt safe living at the home one person said "yes I'm very happy here, feel very safe". Another person told us told us that they were very happy living at the home, they said: "this is a good home my care worker is very good, kind and caring, in fact all the staff are and yes I feel safe".

Some of the people spoken with told us that there were times when they had to wait for staff to respond to their request for assistance. One person said "I was up until 1am last night I think they were short staffed" and another person told us that on one night they had asked for a drink at 12.45am and had been told that staff were too busy "putting people to bed".

Before we carried out this inspection a person who wished to remain anonymous had told us that the home was short staffed. The registered manager had acknowledged that the home had staffing difficulties but was endeavouring to recruit suitably qualified and competent staff and in the interim was using temporary staff supplied by an employment agency.

When we started our unannounced inspection we could see that there was a sufficient number of suitably qualified and experienced staff on duty to meet the needs of the people who lived at the home. The registered manager was on annual leave but the care team leader, who was in charge of the home presented as a competent, experienced and suitably trained member of staff. They had a detailed knowledge of the needs of the people who lived at the home and were able to provide care staff with adequate supervision and direction to ensure they provided safe and effective care. However, a problem manifested, in the afternoon when a new shift started at 3pm. The care team leader who was rostered to commence the afternoon shift at 3pm was late. They had been contracted to work at the home via an employment agency and they had never worked in the home before. The care team leader who had been on duty in the morning left before the agency care team leader started the afternoon shift and was therefore unable to provide them with a suitable introduction to the home or a handover .

The agency care team leader who was in charge of the home in the afternoon and evening of the first day of our inspection was unable to tell us how many people were resident at the home, whether any one was subject to a deprivation of liberty safeguard, whether anyone was at risk of falls, malnutrition, dehydration, leaving the home unsupervised or whether anyone was waiting to see the doctor. They told us that none of the people living at the home had diabetes but we were later informed that this information was incorrect. They told us that they only had a list of names of people and relied upon one of the care staff to inform them of the needs of people who lived at the home. We spoke with this member of the care staff team to ascertain information about the care of a person, but they told us that they were not familiar with their care plan.

We asked the agency care team leader about action to take in the event of a fire and they demonstrated that they had little or no understanding of the home's fire procedures. They told us that they had not been shown where the fire panel was. They said they would call the fire brigade and await their instruction. We asked whether they would attempt to evacuate people to a safe area within the home and they answered they would await instructions from the fire brigade. The three care staff who were on duty with the agency care team leader had a better understanding of people's needs but none of them could say with any accuracy how many people were living at the home. We asked all three care staff and the activities organiser as to how many people were living at the home. Their answers ranged from 33 to 37. There were 31 people were living at the home at the time of the visit. We could see that the people who lived at the home were at risk of their needs not being met and receiving unsafe care especially in the event of a fire..

In the light of concerns raised by people who lived at the home regarding staffing at night time we carried out an unannounced visit to the home on 1 October 2015 between the hours of 9.50pm and 12.17am. We found that there was a sufficient number of suitably competent staff on duty. The atmosphere was relaxed and sociable. A number of people were still up and about but all of them told us that this was in accordance with their wishes. We could see that

Requires improvement

Is the service safe?

staff had sufficient time to meet people's needs and had everything under control. However, staff told us that the home was short staffed and the registered manager often struggled to cover shifts especially at short notice. They told us that there had been such an incident on the previous weekend, when the care team leader rostered to work the night shift had telephoned after 9pm to say they were unable to do the shift. Consequently a recently appointed care worker, who was still on probation, was asked to work that night shift.

We checked the staff rota for 27 September 2015 and could see that the night shift was worked by an experienced care assistant and a relatively inexperienced care assistant who was still on probation. Staff training records showed that neither of these staff were trained to administer medication or administer first aid. This meant that should any of the people who lived at the home have needed medicine prescribed on an 'as and when required' basis, or first aid, there was no one trained to administer it safely.

We spoke with the recently appointed staff member who had worked the night shift on 27 September 2015. They told us that they had completed their induction on 2 October 2015. We could see that they had benefited from their induction training but were unfamiliar with the home's fire procedures. This meant that in the event of a fire the people who lived at the home would have been at increased risk because all staff were not familiar with the home's fire procedures.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Sufficient numbers of suitably qualified, competent and experienced staff were not deployed to meet the needs of the people living in the home.

We saw that the service had a safeguarding procedure in place. This was designed to ensure that any problems that arose were dealt with openly and people were protected from possible harm. The registered manager was aware of the relevant process to follow. However, our inspection of the home's records identified a letter dated 6 August 2015 in which the author had alleged abuse. The registered manager told us that these allegations had not been investigated, reported to the commission or reported to the local authority in accordance with locally agreed safeguarding policies and procedures.

On 3 September 2015 we told the registered manager that the allegations detailed in the letter dated 6 August 2015 constituted an allegation of abuse which must be reported to the local safeguarding authority without delay. The registered manager told that this would be done immediately and on 5 October we received a notification confirming that the allegations had been reported to the local authority on 3 September 2015. However, when we contacted the local authority on 12 October 2015 the local authority told us they not been alerted to the allegation of abuse. The manager told us that he had sent an email to the local authority containing the alert on 4 September 2015, but had not received confirmation the email had been delivered and had not followed up when the local authority failed to reply.

Following our inspection visits we spoke with a district nurse who described an incident where an extremely vulnerable person had not received prescribed pain relief when it had been required. The District Nurse told us that they believed this happened because of poor communication amongst care staff and a lack of person centred care planning. The nurse informed us that this had been brought to the registered manager's attention at the time. What the nurse described amounted to a suspicion of neglect. We spoke with the registered manager, checked our records and we spoke with the safeguarding authority about this alleged incident. We found that it had not been investigated or reported to the commission or reported to the local authority as in accordance with locally agreed safeguarding policies and procedures.

The above were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was not following appropriate safeguarding procedures and vulnerable people were at risk because allegations or suspicions of abuse were not being acted upon.

Risk assessments were in place for each person for a range of areas such as nutrition, moving and handling, skin integrity and falls. There was however, some room for improvement in respect of risk assessment. We saw one example where a person's risk assessment had not been reviewed subsequent to them suffering a fall. We found that another person had a pressure mat in their bedroom. This was mentioned in their life plan but only in so far as it should be turned on when the person went to bed because

Requires improvement

Is the service safe?

they wandered. There was no evidence of any assessment or risk assessment as to why this pressure mat was required or any indication that the person had given consent to it being used.

Another person had a medicine used for the skin in their bedroom on an open shelf. A risk assessment in their care file showed they had a history of swallowing foreign materials but there was no risk assessment to support the safe use and storage of this medicine. Staff told us that they did not know why this medication was being stored in this person's bedroom and the agency care team leader on duty at the time was unaware that the person was at risk of swallowing foreign objects.

This is a breach of Regulation 12(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was not consistently assessing the risks to the health and safety of people receiving care or treatment.

We checked the medicines and records for six people. We spoke with the manager of the home and one of the care team leaders with responsibility for medicines. We found that medicines were not always given as prescribed by the doctor. A person who was taking a medicine for pain relief had only been given it once a day rather than twice a day; the person had said that their pain was currently not controlled. A second person did not have their anti-inflammatory cream applied regularly. A third person who needed eye drops had missing signatures on the Medicine Administration Record (MAR) chart for two days.

The home had four medicine rounds. The timing for the medicines rounds was four hours apart for the lunch, dinner and night time. When we visited, there was no time documented for when paracetamol had been given and therefore it would be difficult to ensure a minimum of four hours time interval had passed between paracetamol doses with the current timings on the MAR chart. There was no procedure for giving medicine with specific instructions, such as to be taken before food or to be taken after food. For example a person's morning medicine would be administered to the person all at once making it difficult to take medicines as per instructed by the doctor and drug company.

We found that care records were not easy to find and were not always completed. Two people did not have their allergy box completed which is against current guidance.

One person's notes from an outpatient clinic to monitor a medicine to thin the blood could not be found. One person was taking a pain killer to be taken when required; however there was no care planning to support the safe administration of this medicine. We looked at four people who were prescribed creams from their GP; however there were no body maps or written life plans to direct carers on where the cream should be applied. One person who was self-medicating did not have a risk assessment in their life plan as suggested in national guidance. Another person had a medicine used to reduce cholesterol stopped on their MAR chart but there was no record of who had told the home to do this in the person's care records..

Medicines and personal confidential data were not always safely locked away; the medicines fridge that was unlocked was kept in a room that had no lock on the door. This room contained drawers and cupboards with personal information in it that were unlocked also. The record of current, minimum and maximum fridge temperatures could not be found by the home. This meant that staff could not provide evidence that medicines were kept at the correct temperature, which may affect their effectiveness. The home did not have an effective process for disposing of unwanted medicines. The fridge contained medicines that people no longer took, some of which dated back to January 2015.

The manager told us medicines audits had been completed but the results could not be found.

These issues constitute a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was not consistently assessing the risks to the health and safety of people receiving care or treatment; and was not ensuring the proper and safe management of medicines.

We looked at the files for the two most recently appointed staff members to check that effective recruitment procedures had been completed. We found that the appropriate checks had been undertaken to help to minimise the risk of employing unsuitable people to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions to help prevent unsuitable people from working with vulnerable groups.

Requires improvement

Is the service safe?

We saw from these files that the home required potential employees to complete an application form from which their employment history could be checked. References had been taken up in order to help verify this. Each file held a photograph of the employee as well as suitable proof of identity.

There was also confirmation within the recruitment files we looked at that the employees had completed a suitable induction training programme when they had started work at the home.

We found that the people living in the home had an individual Personal Emergency Evacuation Plan in place. This was good practice and would be used if the home had to be evacuated in an emergency such as a fire.

Following the first day of our inspection the registered manager drew up an action plan designed to ensure that required improvements were made to ensure people received safe and effective care. This included a more thorough handover procedure and detailed fact sheet which outlined each person's headline health and social care needs. This will help to improve communication in the home and assist agency staff to familiarise themselves with people's needs. The registered manager must ensure that these improvements are sustained.

Requires improvement

Is the service effective?

Our findings

Most of the people spoken with during the inspection told us that care was effective and they made positive comments about the home and standard of care received. Comments included: "this is a lovely home, the best thing is the freedom to do what you want without staff telling you what to do. The staff are lovely always treat me with respect and the food is lovely", "this is a good home, staff are kind and caring and the food is good, with plenty of choice" and "we could not reasonably expect anything better, the staff are knowledgeable, confident and lovely, they always treat me with dignity and respect and the food is good with lots of choice." One person told us that they used to like to sit out in the garden but were not allowed and the person sat next to them said it is true "we would like to go outside but we can't".

Some people recalled giving written consent to care, but most people spoken with were unable to recall seeing or signing their life plans.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS). are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

The Care Quality Commission is required by law to monitor the operation of DoLS. Staff told us that two people who lived at the home were subject to DoLS authorisations and when we checked the records we could see that appropriate documentation was in place. However, we could see from records, information provided by staff and our own observation that the registered provider did always not act in accordance with the Mental Capacity Act 2005.

A risk assessment in one person's care file stated that the person used to go out by themselves but it was no longer safe for them to do so. It was recorded that this decision had been discussed and agreed with the person and their friend and that a DoLS had been applied for. There was no MCA assessment regarding this person's capacity to agree to this restriction although the fact that a DoLS had been applied for indicated that staff doubted that the person had mental capacity to do so. The registered manager told us that an application had been made to the local authority for a DoLS standard authorisation prior to the decision taken to limit the person's freedom of movement. However, when we contacted the local authority's MCA/ DoLS Best Interest Assessors they told us the application had not been received by them until 2 months after the decision was made. This indicates that the person was subject to an unauthorised deprivation of their freedom of movement.

Another person's care file contained a life plan which stated that they should be monitored closely and were not free to leave. There was no evidence in the person's care file that they had given consent to these restrictions and no MCA assessment regarding their ability to give consent or evidence that a best interest decision had been made in accordance with the MCA. The registered manager told us that a DoLS standard authorisation had been applied for, which confirmed that staff had doubts about this person's capacity to consent to care but no MCA assessment or best interest decision had been recorded on the person's care file.

Another person had a sensor mat placed in their bedroom. Care staff told us that this was because the person wandered during the night. However, there was no risk assessment in the person's care file to say why such a restrictive action was necessary. The life plan titled "Preparing for sleep" mentioned it but only insofar as that it needed to be turned on when the person went to bed. There was no indication that the person had consented to the use of the pressure mat and no MCA assessment regarding their ability to give consent or evidence that a best interest decision had been made in accordance with the MCA.

The issues stated above constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In providing care and treatment of service users the registered provider did not act in accordance with the Mental Capacity Act 2005.

It was a lovely sunny day when we started our inspection and we wondered why people were not sitting out at the front of the home enjoying the good weather. We asked several people why not and they told us that they would love to go outside and but they were not allowed to do so. There was a coded lock on the front door which prevented people from coming in or going out unless they had the code. We raised this matter with care staff who told us that

people were not given the code because of safety reasons. Further discussion with senior staff and the registered manager identified that the restriction on these peoples liberty of movement had not been risk assessed, justified or agreed with them or their representatives.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The freedom and liberty of movement of some of the people who lived at the home was being controlled in a way that was not proportionate to the risk of harm presented to the person or others.

Care staff presented as kind, caring and compassionate but lacked important knowledge about the people who lived at the home and important aspects of care. For example some care staff had heard of DoLS but did not know what they were. Others lacked knowledge about the content of life plans and told us that they did not read them. Two staff members spoken with were unfamiliar with the home's fire procedures and a third person told us that they had never been involved in a fire drill and were concerned as to how people living on the first floor would be evacuated. They were unaware that each person living in the home had an individual Personal Emergency Evacuation Plan in place.

The staff training matrix showed that seven staff were overdue their yearly observation on moving and handling, which is necessary to check that they carry out the procedure safely and effectively. Three of the five staff members trained in the administration of medication were overdue their refresher training. Four staff members were overdue training on safeguarding and protection of vulnerable adults. Three staff were overdue training on infection control. Three of the six staff trained in first aid were overdue their refresher training. Three staff members were overdue training on food safety and five staff were overdue their hand hygiene fresher training.

Two members of the care staff team who had worked the night shift on the 29 September 2015 alone did not have training in first aid or in the administration of medication. This meant vulnerable people were at risk of their needs not being met.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider has not ensured that persons employed in the provision of the regulated activity have received such training as is necessary to enable them to carry out the duties they are to perform.

We spoke with three members of the care staff team about support and supervision. Two care staff members told us that they had only one supervision session in the last 12 month period and one staff member told us that they had never had supervision since they started working at the home. The registered manager told us that they were responsible for the supervision of care team leaders but had not provided any since they started work at the home in May 2015 The registered manager told us that they had not had the support of a home services manager and vacancies for care team leaders had meant that he had not had time to carry out staff supervision meetings or appraisals. Records showed that the care team leaders had provided supervision for three members of the care staff team in June and two in July, but none in August or September 2015. The registered manager told us that he was unable to say whether staff had had supervision prior to May 2015 because records were not available. The registered manager told us that he had completed an observation of one of the care team leaders administering medication in July 2015 but was unable to provide a record of the outcome.

We recommend that the manager ensures that all staff employed in the provision of the regulated activity receive such support supervision and appraisal as in accordance with the providers policies and procedures to enable them to carry out the duties they are to perform.

People told us that they loved the food which was well cooked and provided plenty of choice. There was a flexible menu in place which provided a good variety of food to the people using the service. The catering staff we spoke with explained that there was a four week menu which was provided by the provider with input from a nutritionist.

Choices were available and people could decide what they wanted at every mealtime. Special diets such as gluten free and diabetic meals were provided if needed. The people we spoke with confirmed that choices were available and that they could choose whether to eat their meals in their own room or the dining room. We observed lunch and saw

Requires improvement

Is the service effective?

that there was a calm and pleasant ambience. We observed staff members asking people what they wanted to eat. Snacks including fresh fruit and yogurts were available and biscuits were routinely offered with drinks.

We looked at life plans for four people that addressed nutrition. These demonstrated that people's weight was monitored and all were maintaining a healthy appetite without any signs of unintended weight loss.

Good

Is the service caring?

Our findings

All the people who were up and about in the communal areas of the home were smartly dressed, clean and well presented. Most had smiles on their faces and although their views differed all had something positive to say about the staff and the way care was provided. One person said: "This is a good home, I am very happy here. My carer is very good, she knows my needs and is very kind and caring, all the staff are. There is always someone to talk to, I feel safe and all my needs are met. The food is good too". Another person said: The staff are knowledgeable, confident and lovely, they treat me with dignity and respect, always. The food is very good, always choice. The manager is very good too. We have to wait for the call bell to be answered but they come when they can.

We saw people laughing and joking with staff, and it was clear to us that there were trusting relationships between the staff and the people who used the service.

We also saw staff treating people with dignity and respect. When staff provided personal care, they approached the person sensitively, discreetly asking them if they needed assistance. Staff always knocked on bedroom doors before entering and ensured doors were shut when carrying out personal care.

We observed people in the dining room over lunch and saw that people were being supported appropriately. We saw staff members responding to people needing assistance, offering choices, and supporting them with timely prompts to encourage them to eat and enjoy their lunch. We could see that staff gave consistent but sensitive encouragement to a person whose appetite was poor. They ensured that the person was offered food that was palatable and did not 'over face' them and always respected their preferences and choices.

People told us that the registered manager listened to them and engaged them in decision making about the way the home was run. For example they had recently voted to change the time of the main meal because most people wanted a lighter meal in the evening. The cook said "really I just do what they ask for".

The quality of decor, furnishings and fittings provided people with a homely and comfortable environment to live in. People's bedrooms were personalised and contained photographs, pictures, ornaments and the things each person wanted in their bedroom. The locks on some of the bathroom and toilet doors were found to be inoperable on the first and last day of the inspection but were working on the intervening days. The manager explained that this was a recurring problem. The design of the locking mechanism was prone to failure and maintenance staff were in the process of exploring a more permanent solution to the problem.

People's wishes for end of life were recorded. For example, some people had a do not attempt resuscitation (DNAR) order document in place and an advanced care plan (a plan of their wishes at the end of life). We saw that the person concerned and their family were involved in this decision.

The provider had developed a range of information, including a brochure for the people living in the home. This gave people detailed information on such topics as medicine arrangements, telephones, meals, complaints and the services provided.

Requires improvement

Is the service responsive?

Our findings

The atmosphere in the home throughout our inspection was relaxed and sociable.

Although only a minority of people spoken with could recall seeing their care plans some people told us that they felt involved in decision making and care planning and the manager, senior staff and care staff respected their views. All the people we spoke with had something positive to say about the home and the standard of care received but their experiences had not always been positive.

On the first day of our inspection one person told us that they were dissatisfied with the care they received. They told us they understood they could have more than one bath a week but in practice there were times when they had not been offered even one bath. Bathing records showed that this person had only had one bath in last month.

Their life plan which they had agreed to and signed, recorded their preference for three baths a week. We spoke with this person again on 1 October when they told us they were still not baths as regular as they would like despite their relative raising concerns at the end of August 2015. We checked the bathing records again late in the evening on 1 October 2015 and could see that this person had not been offered a bath in the last seven days. We looked at their life plan again and found that it had been re-written since we last saw it on the 28 August 2015. The new care plan was not signed by the person, and did not mention their preference for 3 baths a week. This new life plan was dated 26 August 2015 predating our first visit to the home, it appeared to have been inaccurately dated as it was not in place when we checked the care file on the 28 August 2015. This re-writing of the life plan disregarded this person's preference for three baths a week and was written without the person's involvement.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a person centred way that met the person's needs and reflected their preferences and care was not being designed in such a way that would ensure the person's preferences were met.

We spoke with two visiting doctors and three district nurses as part of this inspection. They all complimented the care staff on being kind, compassionate and caring but all raised concerns about poor communication, care planning, monitoring and review. They gave an example where poor communication had resulted in a vulnerable person suffering unnecessary pain and discomfort because staff had not acted promptly on doctors instructions. We found further evidence of poor communication with district nurses which resulted in a delay in a person getting medical treatment to a wound they suffered as a result of a fall. The daily care records for this person showed that they had fallen in the home and a body map dated the following day recorded that they had been injured but there was no record of the person receiving any medical assessment or treatment of their injuries. The staff member who was in charge of the home at the time of the incident told us that they had asked a district nurse to attend to the person's injuries but there was no record of this in the care file. We spoke with the district nurses and they confirmed that they had assessed and dressed this person's wounds but had not been informed of them until two days after the fall. District nurses told us that they provide a 24 hour service but in this case the staff did not follow the established protocol of making contact with them to alert them that the person had been injured. The district nurse who attended to the person was only told about the injury when they were visiting the home to attend to another person.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Care and treatment was not provided in a safe and timely way to ensure the health, safety and welfare of people who lived at the home.

One of the people who lived at the home experienced periods of confusion and agitation. We observed them making several attempts to leave the home, rattling doors and asking to be let out. Activities records showed that this person had been taken out of the home with the activities organiser, four times in May and three times in June 2015, but there were no records of the person being taken out in July or August 2015. A standard DoLS authorisation was in place. This authorised the home to deprive this person of their freedom to leave the home unsupervised in their best interests. Their life plan on getting out and about stated that the person had been prescribed a medicine to reduce agitation when needed but there were no further details or guidance for staff on how to reduce the effects of this person's anxiety which was probably exacerbated by the fact they were locked in. We observed care staff attempting to calm this person by engaging them in conversation for short periods of time but as soon as the staff member

Is the service responsive?

moved on the person's anxiety returned. We asked the member of staff what guidance was available in the person's care plan as to how to respond to their anxiety. They told us that they had not read the person's life plan so did not know. We asked a senior staff member as to what they would expect staff to do. They told us that there was no life plan on how to respond to this person's anxiety other than giving them the medicine the doctor had prescribed. We looked at the person's life plans and could see that there was no life plan as to how this person's anxiety might be reduced practically through distraction, exercise or engagement in a rewarding activity. Medication administration records showed that the staff gave the person their medication as prescribed by their doctor but their anxiety persisted. There was no evidence of any analysis or evaluation as to what strategies might work best to reduce their anxiety.

This was a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a person centred way that met the person's needs and reflected their preferences.

The registered provider had a complaints policy and procedure to record and respond to any complaints, ensure that concerns were addressed within given timescales and ensure that effective action was taken to improve the service, where necessary. Complaints were recorded in a file along with records of the investigations which took place and the outcome achieved. However, we could see that registered managers had not always acted in accordance with the complaints procedure.

A visiting doctor told us that they had written a formal letter of complaint to the previous manager of the home earlier in the year but had not received an acknowledgment or response. There was no record of the home receiving such a complaint and the registered manager told us that he had no knowledge of such a complaint.

Whilst inspecting the home's record system we came across a formal letter of complaint from a member of staff. There was no record of this in the home's complaints records and no evidence that it had been investigated or responded to. The manager told us that he had not investigated this complaint because he believed it was malicious.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not always fully investigated complaints or taken necessary and proportionate action in response to a complaint.

Some staff spoken with had an excellent working knowledge of people they cared for but others were unfamiliar with information recorded in people's life plans. A number of care workers told us that they did not have time to read life plans and we could see that they provided care intuitively or on the basis of knowledge they gleaned from the person and other staff members. Whilst care staff were well intentioned we could see that there was room for improvement in person centred life planning. Person centred life planning is essential in a residential care setting because it helps to ensure that people receive care in a way that is acceptable to them and meets their needs and personal preferences. The registered manager told us that he was aware that person centred care planning needed further development in the home and that he had developed an action plan to ensure the required improvements were made. The action plan included a commitment to ensuring that all care staff were involved in reviewing life plans and capitalising on further training on person centred care.

We found that the home was welcoming, relaxed and sociable, throughout the inspection. On arrival we observed a care worker assisting a person from the dining room. We could see that the care worker was offering assistance in a kind and considerate manner. They promoted choice and independence by asking the person where they wanted to go and what they wanted to do.

We could see that people were engaged in a number of hobbies and activities. They were clearly enjoying interacting and socialising with each other and their visitors.

We could see that staff were attentive and receptive to people's needs. For example we observed one member of staff offering comfort to a person who was anxious, simply by holding their hand for a short while. This moment of care, kindness and consideration brought a rich smile to the person's face and whatever had been troubling them seemed to pass.

Requires improvement

Is the service well-led?

Our findings

The provider had an established quality assurance system but this was not always fully implemented or adhered to. The manager told us medicines audits had been completed but the results of the most recent audits for August and September could not be found during the visit. A previous medicines audit for July 2015 was only part completed. An email addressed to the registered manager was attached to the medicines audit dated July 2015. This highlighted that the audit had not been completed and that checks had not been made as to whether the medicines room and medicines fridge temperatures were being monitored. We could see that audits of the medication procedures had failed to identify the issues relating to the safe receipt, storage, administration and disposal of medication which we identified during the inspection.

The manager told us that he was aware that people's life plans needed further development to ensure their needs were met and he had implemented an action plan to secure the necessary improvements. Life plans were being audited at a rate of thirteen a month but the life plan audits we checked had not identified omissions and shortfalls which remained evident at the time of the inspection.

Falls monitoring was carried out by the registered manager on a monthly basis. However, it was not effective in that it did not identify shortfalls or where improvements needed to be made. On 5 October we checked the falls monitoring records for August and September 2015. We could see that the falls monitoring records were incomplete. There was no mention of falls that had occurred in the home on 9 August, 14 and 29 September 2015. There was no indication that these falls had been investigated.

We found that allegations of neglect had not been reported to the local safeguarding authority and had not been investigated thoroughly. This was because the registered manager and senior staff had failed to follow the provider's safeguarding policies and procedures.

We found that management had failed to respond effectively to complaints received concerning the wellbeing of the people who lived at the home.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes established to ensure compliance with the regulations were not operated effectively so the health and well-being of the people who lived at the home was not assured.

Our inspection of the home's records identified two incidences of alleged neglect which should have been reported to the commission without delay. The commission had not received notification of either incident until October 2015 following the matter being raised with the registered manager.

We also found that a person who used the service had sustained a serious injury which had not been reported to the commission in accordance with the requirements of the regulations.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009. The registered provider had not notified the commission of two incidents of alleged abuse and an incident involving a serious injury without delay. We are corresponding with the provider to address this issue.

People, who lived at the home told us that the registered manager was accessible, listened to them and involved them in decision making. We could see that the provider's quality assurance systems were based on gathering the views of the people who lived at and used the services. The most recent survey had been completed in 2014 and was published in a report available to all the people who lived at the home and their relatives and advocates. This showed that 10 people responded to the survey and indicated a high degree of satisfaction with facilities and services provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not always provided in a person centred way that met the person's needs and reflected their preferences and care was not always being designed in such a way that would ensure the person's preferences were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe and timely way to ensure the health, safety and welfare of people who lived at the home. The registered provider was not consistently assessing the risks to the health and safety of people receiving care or treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent In providing care and treatment of service users the registered provider did not act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider had not always fully investigated complaints or taken necessary and proportionate action in response to a complaint.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes established to ensure compliance with the regulations were not operated effectively so the health and well-being of the people who lived at the home was not assured.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent and experienced staff were not deployed to meet the needs of the people living in the home. The provider had not ensured that persons employed in the provision of the regulated activity had received such training as is necessary to enable them to carry out the duties they are to perform.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider was not following appropriate safeguarding procedures and vulnerable people were at risk because allegations or suspicions of abuse were not being acted upon.

The enforcement action we took:

We have served a warning notice to be met by 30 December 2015.