Moorland House Limited

Moorland House

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**

Overall summary

This inspection visit took place on 23 and 28 October 2015 and was unannounced.

Moorland House is a small, privately owned residential home providing care and support for up to twenty older people, some of whom are living with dementia. There were seventeen people using the service at the time of this inspection.

The service 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.

People were not protected from the risk of avoidable harm and improper treatment because managers and staff did not always recognise potential abuse.

Risks to people's health and welfare were not always assessed and reasonable steps were not always taken to mitigate risks.

Summary of findings

Medicines were not always managed in a safe and proper way to protect people.

Recruitment procedures were not robust and relevant checks were not always completed appropriately to make sure staff were suitable for their role.

Staff did not follow legislation designed to protect people's rights and ensure decisions taken on behalf of people were made in their best interests.

The systems in place to monitor the quality and safety of the service were inconsistently applied.

We have made a recommendation about making the environment more suited to the specialist needs of people living with dementia.

We have made a recommendation about supporting people who are living with dementia to make choices about eating and drinking.

Overall, people received support to have sufficient to eat and drink. Staff were aware of those people who required assistance with eating and drinking. People's comments about food and drink were mostly positive.

People were protected by the procedures that were in place for the prevention and control of infection.

Staff were responsive to people's changing health needs and supported them to access healthcare professionals. Where people used their call bells we saw staff responded promptly.

People did not always receive personalised care that was responsive to their needs. We observed staff were very busy with tasks and did not have much time to spend interacting socially with people. Staff were aware of people's overall care needs and support preferences and approached and spoke to people in a friendly and helpful manner.

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

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Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from the risk of avoidable harm and improper treatment.

Risks to individuals were not always assessed and managed so that they were protected and their freedom respected.

Medicines were not always managed so that people received them safely.

Recruitment procedures were not always completed appropriately to make sure staff were suitable for their role.

Is the service effective?

Requires improvement

The service was not always effective.

Consent to care and treatment was not always sought in line with current legislation and guidance.

The programme of staff training and development was not up to date.

The environment was not ideally suited to meet the needs of people living with dementia.

People had access to healthcare services when they needed them.

Is the service caring?

Requires improvement

The service was not always caring.

Staff were mostly kind and caring in their approach, but did not have much time to spend interacting socially with people.

Staff showed a good understanding of privacy and dignity, however people's privacy and dignity was not always protected.

Is the service responsive?

Requires improvement

The service was not always responsive.

People did not always receive personalised care that was responsive to their needs.

Staff were prompt to raise issues about people's health and wellbeing and people were referred to health professionals when needed.

Is the service well-led?

Requires improvement

The service was not always well led.

The systems in place to monitor the quality and safety of the service were inconsistently applied.

Summary of findings

The management of the service were reactive rather than proactive in identifying and minimising risks.

Staff told us they felt well supported by the registered manager.

Moorland House

Detailed findings

Background to this inspection

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

This inspection visit took place on 23 and 28 October 2015 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited the home we checked the information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with seven people who used the service and a relative to seek their views about the care and support being provided. We also spent time observing interactions between staff and people who used the service.

We spoke with five care staff and one domestic staff, the registered manager, deputy manager and a visiting healthcare professional. We reviewed a range of care and support records for four people, including records relating to the delivery of their care and medicine administration records. We also reviewed records about how the service was managed, including staff recruitment and training, risk assessments and quality audits.

Inadequate

Is the service safe?

Our findings

We received mixed views from people about how safe they felt in the service. People's comments included: "I feel safe here, safer than being at home on my own". "I feel safe here, there are no worries they look after us well"; and "I don't really feel safe but they look after me well".

Staff we spoke with confirmed they received training in safeguarding adults who may be at risk but we found this did not translate into practice. Although staff were able to describe different forms of abuse and how they might relate to the people being supported in Moorland House, we found instances of potentially abusive practices that were not being recognised. For example, people being strapped into their chair or given medication for unclear reasons.

Staff training was inconsistent. The training records for sixteen staff showed that safeguarding training was out of date for eight staff with three staff having last received training in September 2013. Five did not have any training recorded. The registered manager said that updated training was booked for November 2015. The registered manager was also unclear about her safeguarding responsibilities. A person told us that recently, another person had thrown a table at them when in bed and injured their leg. When tracking both individual's care files we saw this had occurred on 10 October 2015, causing a 'large blood bruise' on the person's leg. We spoke with the registered manager about this concern, regarding it being reported as an assault and reported to the local authority safeguarding team but this had not been done. They did not refer the incident to the relevant authority even after we prompted her to do so.

We observed a person who was being restrained in a wheelchair by a lapstrap on the first day of the inspection. Mid morning on the second day of this inspection we saw the person was again sat in a wheel chair with the lapstrap attached. The person was arching their back and straining against the strap and was clearly uncomfortable. There was no cushion beneath them. We asked a member of staff why the person was in the wheelchair and they replied the person was at risk of mini strokes and falls. Staff then released the person from the wheelchair and the person walked around the home during the rest of our inspection visit.

A visitor told us "They put her in a wheelchair with a strap because she walks all the time. They only do it so she will have a hot lunch and then they let her out. She tries to stand up all the time. They have to watch her all the time because she has had so many falls". Staff failed to recognise that this was a restrictive practice and failed to assess less restrictive options to support the person.

The failure to recognise and protect people from abuse and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew who to contact if they suspected abuse was taking place. Staff comments included " We have to ensure that everyone is safe and if there are any concerns, report it straight away to the manager".

Staff we spoke with were aware of the need to promote people's independence whilst protecting them from risk. Each area of people's care plans contained a section for risk assessments, including falls risk assessments, skin integrity, nutrition, environmental assessments and risks to health.

However, we found risk assessments were not always carried out and where a risk was identified there was not always a clear and effective plan to manage it. We examined the charts to be completed each time people received a bath or shower. The registered manager told us that to date staff had not been using or completing temperature charts as there were safety temperature regulator controls on the water system. We advised the registered manager about the risks of scalding to people should the water temperature regulators fail. They took immediate action and on the second day of the inspection we saw that water temperatures were being recorded.

When visiting one female person in their bedroom over a fifteen minute period, we noted that another male user of the service opened the door and came into the room on ten occasions. The person told us that they spent quite a lot of time in bed and this happened all the time. They said they felt afraid and upset by the intrusion. The person said that another male resident also came into their room. The person said "It's in and out, in and out all the time, they don't speak to me and it's driving me mad". Daily records showed that records of incidents were kept from 18 September 2015.

We discussed with this person the impact the intrusion was having on them. There was no specific risk assessment in

Is the service safe?

place to guide staff on how to keep this person safe. On the second day of the inspection both people had been moved to different rooms. One person said "It's much better now, I feel safe and I am really happy".

With regard to the person who carried out the incident, records showed that this person was living with dementia, was constantly walking around the home and at times gave expression to behaviours that were challenging and worrying to other people. Behaviour monitoring charts were in place and the manager said these would be passed to the mental health team for further input and assessment. Records showed that this person was constantly walking around the home, grabbed people's food at mealtimes and exposed themselves in communal areas. The behaviour monitoring charts did not match with other records for the person and therefore would be ineffective in tracking the behaviours.

In this person's bedroom on the first floor the window was opened wide enough for the person to climb through, though a window restrictor was in place. A low chest of drawers was placed in front of the window, on which a person could climb. This person was living with dementia, was constantly on the move and had been assessed as lacking insight into risks. A bedroom risk assessment was recorded for each person, however this person's risk assessment made no reference to the window.

When examining the safety of the environment we noted that for some people, their bedrooms contained a pressure mat alarm at the side of the bed. This would mean that people had to get out of bed to alert the staff in the night if they required assistance. We discussed this with the registered manager who told us that as most of the people were living with dementia, they would not know how to use the call bell. The registered manager said two hourly checks were carried out by night staff and this would be more frequent if staff identified that someone was unwell. However, there were no risk assessments in place to demonstrate how people would call staff in an emergency or if they required assistance, without them having to get out of bed. In other rooms the call bells were attached to the walls without a lead. We spoke with one person who was not feeling well and told us "The bell is over there, I have to get up to use it". Whilst the pressure mats supported some people to be independent and for staff to be able to assist if needed, for other people the lack of risk assessments meant there was a risk of people falling whilst trying to gain assistance.

On the second day of the inspection we observed three people being hoisted from armchairs in the lounge and moved into the 'quiet lounge' to be served with lunch. We asked the staff if people were assessed for having their own individual slings and were told that they were. We then saw the staff use the same sling for all three people. When asked why this was the staff replied it was because "(Person's) sling is in the wash". At the end of the inspection visit the registered manager told us she was looking into obtaining more slings.

The failure to assess risk and do all that is reasonable practicable to mitigate risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed so that people received them safely. Records relating to staff training and competency checks were incomplete. There were gaps in the medicines administration records (MAR) and topical creams and lotions were not stored and managed appropriately. Procedures for giving a person 'as required' (PRN) medicines were not in place and this had resulted in the person being given the medicine inconsistently by staff.

There were policies and procedures in place regarding the storage and administration of medicines, but these were not consistently followed. Staff specimen signatures had been recorded, however these included the names and signatures of five staff that had recently left the service.

Senior staff told us they received training and competency checks in relation to the safe handling of medicines. The training records showed that six senior staff, including the registered manager, had been trained to administer medicines. Training records showed that four of these staff had not received training since 9 October 2013. Two records stated that a local pharmacy had provided training but no date of training was entered. There was no evidence of up to date competency assessments having been undertaken recorded either on the training record or in individual staff files.

We looked at the Medicines Administration Records (MARs) relating to all of the people living at the service. We found that there were gaps in staff signatures in a number of the

records with no explanation recorded. There were signatures for four audits being carried out each day following the drugs round, these had been fully signed to date but had not identified the errors in the MAR charts.

One person had been prescribed a number of 'when required' (PRN) medicines. The National Institute for Health and Care Excellence (NICE) guidelines Managing Medicines in Care Homes March 2014 identifies the need for guidance for administering PRN medicines. This should include the reason for giving the medicine, how much should be given, what the medicine is expected to do, the minimum time between doses if the first dose has not worked and the recording of PRN medicines in the person's care plan.' There was no PRN guidance in either the care plans or MAR charts to support staff with the administration of PRN medicine should it be administered. When tracking the MAR and behaviour (ABC) charts for PRN for this person we also noted that there was no consistency with the reasons for administering the PRN, as some staff administered and some did not for the same behaviours recorded. This meant the ABC charts did not give a clear reflection of the behaviours.

In the bedrooms of ten people there were topical creams and lotions with no date of opening or when they should be used by recorded. This included a tube of bleach based denture cleaning tablets, which could pose a risk of poisoning if ingested. There was no guidance in place for staff to ensure they knew how often and where the creams should be used and staff were not recording when they had administered them. In one room we saw that one cream had another person's name recorded on it and in another room a topical cream's guidance stated that it should not be used after 2013. We discussed this with the registered manager who said that administration of topical creams was recorded in the MAR charts. The registered manager said that all staff did not complete the MAR charts therefore the recordings were not being correctly completed. The registered manager took immediate action and by the second day of the inspection we saw that recording charts were in place.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored in a locked cabinet that was secured by being chained to the wall in the dining room. People told us they received their medicines. One person said "I always get help when I need it. I get my medication at the same time every day and they give me painkillers when I want them".

Recruitment procedures were not robust and put people at risk. When tracking recruitment files we noted that robust practice was not always followed when ensuring that suitably qualified and competent staff were recruited. All the required documentation was not in place. In two staff recruitment files examined in one there was only one reference in place, this from a former employer for whom the employee had not worked since 2008. The second referee was named as a friend of the employee and this reference was not in place. The member of staff had been employed as a senior carer but there were no references regarding care posts undertaken or from the last employer. There was also only a Disclosure and Barring Service (DBS) First in place and no record of the full DBS number. There was a note on file saying that a copy of the DBS form had been requested on 23/10/2015. DBS checks enable employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with adults who may be at risk.

For another member of staff who had recently returned to work after a two year absence, there was no 'return to work' meeting undertaken and the employee did not have updates to training or supervisions booked. There was a letter on file saying that the person suffered an ongoing health problem. There was no evidence to show that this person had been booked for updated mandatory training as their name did not appear on the training record.

Another member of staff had been employed to work two nights a week commencing on 10 August 2015. The rota showed they had 'shadowed' an experienced member of staff for their first two shifts, before taking on the role and responsibilities of the waking night care assistant, supported by a sleep-in member of staff, from 16 August 2015. The person's supervision notes dated 8 September 2015 showed they had commenced working as a night worker before references from previous employers had been received. The person had stated in their interview they had undertaken relevant training, such as moving and assisting, with another employer, however the service had not received confirmation of this. The person's file contained a record of a DBS First but no record of the full DBS number.

Inadequate

Is the service safe?

The failure to establish and operate recruitment procedures effectively was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from staff about staffing levels. Some said these were sufficient to meet people's needs, while others said they thought two waking night staff would be safer. For example, if the waking night was assisting someone with personal care they would not be able to support anyone else during that time. Another member of staff said they did not think staffing levels were sufficient at lunch times. We did not find evidence of insufficient staffing. There was the registered manager and three care staff on duty, supported by one domestic staff, the chef and a receptionist. These numbers reflected the staffing levels on the planned staff rotas. The home also had two bank staff available to cover shifts when required.

People were protected by the procedures that were in place for the prevention and control of infection. The home was clean and generally well maintained and staff were provided with personal protective equipment (PPE) such as gloves and aprons. There were cleaning schedules in place and antiseptic hand washes were located throughout the home. Over the two day inspection we saw that staff were aware of infection control issues. We observed them using antiseptic hand washes, wearing protective clothing and changing gloves and aprons to serve meals. However, we found tables were set for the next meal immediately one meal was finished. This meant that cutlery was left uncovered on the tables for a number of hours.

Requires improvement

Is the service effective?

Our findings

People told us "The staff know all about me, it is in my file. The staff are well trained"; and "On the whole the staff seem to be well trained".

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 made on their behalf must be in their best interests and 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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service was not protecting people's rights. Consent to care and treatment was not always sought in line with legislation and guidance. The training record showed seven out of eleven care staff had received MCA and DoLS training. Staff we spoke with were not able to demonstrate knowledge of the basic principles of the MCA code of practice and how these applied to their work and people who used the service. Staff appeared unaware of issues such as the use of lap straps without consent and a 'best interests' assessment being undertaken. An example of this was that we observed one person being moved in a wheelchair at 11:45am. The person had a lap strap in place and was still sitting in the chair after lunch at 2:40pm and was attempting to stand up. There was no mental capacity assessment or best interest meeting notes in this person's care plan.

Care plans did not contain specific capacity assessments or best interest decisions for care and treatment provided. For example there were no assessments or best interest decisions around the use of pressure mat alarms at the side of some people's beds.

The failure to act at all times in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records showed that where required for people's safety, applications had not been requested in line with DoLS and the MCA. A referral had been made for one person and the outcome was on file. People living in the home did not have free access outside the home because there were keypad locks on the outside gates. One person told us "I can go in the garden area, but I have to have permission to go out of the front door". The registered manager did not demonstrate a clear knowledge of MCA and DoLS and was not conversant with the latest ruling by the Supreme Court. This ruling was about the need to safeguard people's choice and independence by submitting mental capacity referrals whenever people's freedoms were potentially restricted.

The failure to act in accordance with the Deprivation of liberty Safeguards Code of Practice was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the end of the inspection the registered manager informed us that training in the MCA and DoLS had now been scheduled for 27 November 2015. The registered manager also confirmed that she would be making the appropriate applications to the DoLS approving authority.

There was a programme of training in place and certificates were kept on file for each member of staff. The training record showed that not all staff had received current updates. This included first aid, safeguarding, MCA and DoLS, safe management of medicines and infection control. The registered manager said that some training was completed on line but this was not being reflected in the training record.

The staff training record showed that fire training was out of date for one member of staff; six staff did not have any dates recorded for fire training so we could not ascertain when they had last been trained. The training record showed that six staff members required updated infection control training.

Staff told us they received an induction and further training. They said all staff had been given folders in relation to the new Care Certificate. One member of staff said they had completed dementia awareness training and told us about

Is the service effective?

types and stages of dementia and effects on functioning. They were able to apply this knowledge to their work with people using the service and gave us examples. They told us "Each person needs a different level of support. Some people remain quite independent, they just need a safe environment. Others need a lot more support".

Staff told us they had supervision and records were on file confirming this. Supervision records were brief handwritten notes, mostly stating that discussions had taken place in relation to single issues, such as blood sugar monitoring and how to move and assist people safely using the equipment provided. We were unable to see from the records what the outcomes of these discussions were and how staff were supported in their ongoing professional development.

There was a record in the kitchen of people's likes and dislikes regarding food as well as any allergies and special requirements. There was a four week menu displayed in the dining room but on the second day of our inspection we noted that the two meals on offer at lunchtime did not appear as a choice on any of the four weekly plans. The meals looked attractively presented and nutritious. We asked the chef how people made a choice and were told that staff went around and asked people in the morning what they would like.

Best practice was not followed to support people living with dementia to eat and drink. We were told no additional prompts such as pictorial menus or 'sample plates' were in use to enable choice for people living with dementia. For one person who did not eat any of their lunch on both days of our inspection, we tracked their records. The records showed that this person had not been eating well for a number of days. There were no monitoring charts in place to enable staff to ascertain if this person was receiving sufficient food and fluid over a twenty four hour period. The tables were laid for lunch by 11am, which could be confusing for people living with dementia. As soon as lunch was finished the table was laid for supper.

We recommend that the service researches and adopts current best practice in relation to supporting people who are living with dementia to make choices about eating and drinking.

Overall, people received support to have sufficient to eat and drink. At lunchtime, people arrived at their own pace and the meal was unhurried. Some people chose to eat their meal in their rooms. We observed a member of staff cut up a person's food for them. Staff were aware of those people who required assistance with eating and drinking. People's comments about food and drink included: "The food is very good we get plenty to eat and drink in here"; and "The food is okay, we usually get a bit of a choice, not an extensive choice. There is plenty to eat and drink but I don't have any drink in my room".

The adaptation and design of the environment was not ideally suited to meet the needs of people living with dementia. There were no handrails in parts of the home to support people to move around independently. The corridors were dark in places because the light bulbs needed replacing. Outside one room the lock was falling off a cupboard, one light was not working. The door handles had been changed on three rooms but large holes were still in the doors. The door in one room was heavy and difficult to open. Clocks in rooms were not telling the correct time at 12 lunchtime the clock said 5:20. Other clocks in rooms had stopped or were telling the wrong time. This could be disorientating for people who are living with dementia.

When checking the environment we noted that in one person's bedroom, their ensuite shower contained equipment such as toilet seats and bowls. We asked the person how they were provided with a shower. They said, "I have to go downstairs for a shower". In another person's bathroom the shower was full of toilet seats. A communal bathroom was also full of toilet seats and other equipment.

The main parts of the environment were warm and homely but there was no equipment or signage in place to support people living with dementia. The manager said that improvments to the environment such as a large extention were planned.

Comments from users of the service included, "It's nice and bright here, they clean my room and it always smells nice." Another person said, "actually it is very nice here, I like my room and the food is okay. I don't see much of the staff though".

We recommend that the service researches and adopts current best practice in relation to environments to meet the specialist needs of people living with dementia.

Care plans demonstrated that people had access to healthcare professionals, this included their local GP, the district nurse team, mental health teams and chiropody

Requires improvement

Is the service effective?

services. People's weights were recorded monthly . We saw that any changes to people's healthcare were recorded in the daily handover notes and families were informed of any concerns. Staff gave examples of how they would respond to a medical emergency, who they would contact and where they would record the incident. People's comments included "You can always see a doctor if you need one and the dentist and optician come here"; and "They normally get someone to see me if I am not well".

Requires improvement

Is the service caring?

Our findings

We received mixed feedback from people about the staff in the service. People's told us: "The staff are very kind and caring"; "The manager is very good to me"; and "I am glad I am here because I am well looked after". One person said "The staff respect me, they know who they are dealing with". A visitor told us "I find the staff kind and caring and very helpful. I looked at five homes before I chose this one for (the person)". A visiting health care professional told us "The staff are very kind and caring here. I have never see anything untoward". Other people told us "They don't really encourage me to do anything, if you can't do it they put me in a wheelchair". Another person told us "Some of the staff listen and some don't; some of them don't show any interest".

We observed care in the communal areas of the home and saw that staff had a good knowledge of the people they were supporting. Staff approached and spoke to people in a friendly and helpful manner. When going to an upstairs bedroom we heard a member of staff taking a drink to a person who had chosen to stay in their room. The person thanked the staff who replied "You are very welcome, now is there anything else that I can do for you before I leave". When helping people to move by using the hoists, staff were patient and kind in their approach and explained to people when they were moving them.

Although staff were kind and caring in their approach, we saw that they were always very busy with tasks and did not have much time to spend interacting socially with people. During the lunch time meal on the first day of the inspection the registered manager and a member of staff were having a conversation while supporting people to eat. Staff spoke to people only about the food they were eating. During lunch on the second day we overheard a member of staff twice telling a person "Elbows off the table".A member of staff poured everyone a glass of orange squash without asking people if they wanted the squash or anything else to drink.

People's privacy and dignity was not always protected. One person walked about the home throughout the day and frequently emtered another person's bedroom, due to it being located at the end of a corridor. We observed this happening on several occasions. The person whose bedroom it was told us "He does this all the time, I have no rest". The person aslo said "He has a brother that does it too". We spoke with a member of staff who told us the 'brother' was another person who also wandered into bedrooms.

The person also told us "(The person) often wanders around with nothing on, takes his trousers off, he does that anywhere. He needs special care. It is not good when the children are visiting and he has his trousers off playing with himself". They also said "I need the toilet I asked a while ago I must wait". We heard a member of staff ask if the person needed the toilet urgently or could they wait. The person chose to wait.

However, staff showed a good understanding of privacy and dignity when we spoke with them. One told us "I knock on the door, say good morning and ask if they want a hand". If giving personal care they would close the door and "Ask if I can remove their clothes and ask them what they would like to wear. I ask the women if they want any make up". They said they involved people in making "Choices about how things are done". Another member of staff said if they thought someone needed to change their clothes, "I would discretely suggest that we go to their room; and encourage them to get changed". They told us they would support people to remain independent, for example in walking or using the toilet, for as long as possible.

It was not clear from speaking with people and reading their care plans how they were involved in the assessment and planning of their care and support. People's comments included: "I am never involved in my care" and "I don't get involved in my care". We did see evidence in people's care plans of relatives and family being involved.

A member of staff told us staff involved people "as much as possible". They said "Most people can tell you what they want and how they want (to be supported)". The member of staff was aware of the importance of confidentiality, for example not disclosing people's information outside of work. Another member of staff said "I would treat people the way I'd like my parents to be treated. For example, not talking about people in front of them".

People were supported to maintain their family relationships and could have visitors at any time.

Two of the care plans we saw contained end of life wishes and the relevant documentation. For other people the end of life forms had been started but contained the words 'to

Requires improvement

Is the service caring?

be completed when the time comes'. We asked the registered manager what this meant in practice and discussed the need to ensure that the service was pro-active in gaining from people and their families their end of life wishes. This would be in order to provide personalised care and help ensure that people's final wishes were recorded and respected. At the end of the inspection the registered manager informed us that she would be contacting the local authority adult services for advice about end of life care planning.

Requires improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. We observed that staff worked in a task oriented manner and often did not engage with people in order to provide social and mental stimulation.

Pre-admission assessments were carried out in order to help ensure that the home could meet people's individual needs. We saw that families and other healthcare professionals were involved in the process.

Care plans contained details such as people's likes, dislikes and preferences for routines. One person told us "I have a shower when I want one I just ask and they come and do it".The plans contained consent forms for the use of records and photographs. The plans were reviewed and updated on a monthly basis by keyworkers and care plan audits were carried out by the registered manager. However, although staff were aware of people's overall care needs and support preferences, care plans did not always reflect people's current individual needs, choices and preferences. One person was grieving over the loss of a long-time friend. There was no care plan in place to support the person during this time. The person told us "My friend died recently and I don't feel I fit in anymore, there is no one to talk to".

Other comments included "I really would like to go to church but I don't know how I would get there. We do have a service here sometimes. I always went to church, we don't go to church in here. The first Monday in the month the church people come but they are not my type of church. No I am not involved in my care".

There was a programme of activities and outings in place and this was displayed in the main hall. On both days of the inspection we saw outside entertainers visiting to provide music in the afternoons. People said that they enjoyed the sessions and they joined in the singing. However their was little stimulation or staff interaction in the mornings as staff were very busy with tasks. This was reflected in the feedback form some of the people we spoke with. For example, one person told us "We get an entertainer two or three times a week, quizzes etc, plenty goes on here. I would like more company, most residents have dementia, there is no one for me to talk to". Another person said "I would like to go for a walk, I can't go on my own but there is no one to take me, the staff are very busy".

We observed that the service did not routinely listen and learn from people's experiences, concerns and complaints. When one person was upset by another person repeatedly coming into their bedroom they told us "I have complained and complained to the staff, they do nothing about it. (Another person) has started coming in now, it makes me feel quite ill. The staff told me there is nothing they can do about it". We pressed the call bell and a member of staff arrived immediately. The person complained about the other person entering their room and the member of staff said they would get them a cup of tea. The member of staff told us "X doesn't do it all the time like Y and Y goes into every room". Then the member of staff smiled at the person and left to get them a cup of tea.

Other people's comments included: "I have no complaints in here, I would tell the manager if I did"; and "I have never complained, there is nothing to complain about. I know how to, I would tell the manager". The provider had a complaints procedure and a copy of this was on display in the home. Other records showed that the registered manager had addressed issues with the relevant staff following the receipt of complaints about the cleanliness of people's bedrooms.

Where people used their call bells we saw staff responded promptly. A person commented "I don't wait long for them to come". Staff were responsive to people's changing health needs. We observed staff responding promptly and efficiently when they identified a concern about a person's health. They contacted the person's GP who came out to see the person. Staff were able to describe the procedures they would follow in the event of an emergency, accident or incident such as a person having a fall.

Requires improvement

Is the service well-led?

Our findings

We received positive comments from people about the service. They included "This home is a place of calm in the quiet lounge. I would recommend this home to my friends and it is nice and clean". "I would recommend this home to my friends. The company is the main thing, we live as family. No one is ostracised, we all join in".

However, the systems in place to monitor the quality and safety of the service were inconsistently applied. An action plan summary was recorded following a monthly audit of infection prevention and control (IPC) measures. However, there were no entries recorded for subsequent actions taken for the August and September 2015 audits. In the July 2015 action plan, follow up actions had been recorded, however these only indicated the required actions had been handed over to various staff and there was no record to show if and when the actions were completed. A senior member of staff told us that actions relating to cleaning would be handed over to the domestic staff and maintenance issues to the relevant staff and we saw records relating to both. The records did not give a clear answer as to the outcomes of the IPC audit.

Gaps in the completion of medicines administration records had not been picked up by the medicines audit. The audit process had also failed to identify and address gaps in the training records relating to staff. People's care plans were not reviewed consistently and did not always reflect people's needs.

The management of the service was reactive rather than proactive. Risks were not always identified and strategies were not in place to minimise the risks. Accidents and incidents were recorded for monitoring purposes. However, there had been no follow up action taken to minimise risk after an incident that occurred on 10 October 2015, in which a person received an injury. The registered manager did not fully understand her role and responsibility in relation to safeguarding people who used the service. Another previous incident had occurred in relation to a person not having a DNACPR form in place when paramedics were called to the service. The registered manager was not able to demonstrate any action was taken by the service to ensure as much as possible that a similar incident did not occur.

The failure to operate effective systems to assess monitor and improve the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us she completed audits and sent the results to the provider. She said the provider and the operations manager visited the home and were "On the end of the phone" if needed. A consultant was also available for advise and support. The registered manager was unclear about how they should be carrying out audits and asked if training was available. We referred them to the Health and Social Care Act 2008 regulations and explained they needed to assure themselves they were meeting the regulations, so they would need to put in place checks that would confirm this. The registered manager had a copy of the guidance for providers on meeting the regulations.

Systems for gathering feedback from people and their relatives about the service were also inconsistently applied. None of the people we spoke with were aware of meetings or feedback. The minutes of the most recent residents and relatives meeting were on a notice board, dated 2 July 2015. The minutes stated that the provider had apologised that there had been a gap of over a year since the last meeting. The provider also responded during the meeting to people's comments received through a quality survey questionnaire, which related to questions about staffing levels and care for people living with dementia.

Staff told us they felt well supported by the registered manager. Their comments included "We can ask for advice any time and I think that we have very good communication". Staff said they received updates from the manager at staff meetings, where they could also raise and discuss any issues. Discussion with members of staff confirmed that policies and procedures for reporting poor practice, known as 'whistleblowing' were in place. Staff said they would not hesitate to report any concerns about the practice of their colleagues and were confident that these concerns would be acted upon immediately.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems and processes were not established and operated effectively to prevent abuse. Staff failed to recognise restrictive practice and to assess less restrictive options for support. Regulation 13(2) and (4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Risk assessments were not always completed and regularly reviewed and actions were not taken to mitigate risks. Regulation 12(2)(a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Staff training and procedures regarding the administration and recording of medicines were inconsistent and did not ensure the proper and safe management of medicines. Regulation 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Staff recruitment procedures were not established and operated effectively. Regulation 19(2)(a).

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 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Consent to care and treatment was not always sought in line with current legislation and guidance. Staff were not familiar with and able to apply the principles and codes of conduct associated with the Mental Capacity Act 2005. Regulation 11(1) and (2).

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 How the regulation was not being met: The provider had not acted at all times in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. People were deprived of their liberty for the purpose of receiving care without lawful authority. Regulation 13(5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The systems in place to assess, monitor and improve the quality and safety of the service were not operated effectively, in particular regard to people's quality of experience; risks relating to people's health and welfare; and maintaining accurate records in respect of service users, persons employed and the management of the regulated activity. Regulation 17(2)(a)(b)(c)(d).