Mr C and Mrs LA Gopaul

Rainbow Lodge Nursing Home

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

The inspection took place on 7 and 8 September 2015 and was unannounced. The last inspection of the service was on 1 March 2014 and there were no breaches of Regulation identified.

Rainbow Lodge Nursing Home is a nursing home registered to provide accommodation, personal and nursing care for up to 20 people with mental health support needs. The provider is a partnership and one of the partners is the registered manager. At the time of our inspection there were 15 people living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 always safe. We found that fire safety arrangements were not being followed and this placed people at risk in the event of a fire.

The service did not have effective arrangements for the management of medicines to protect people against the risks associated with medicines.

Risk management arrangements were not robust and this placed people at risk of receiving inappropriate or unsafe care.

The provider had arrangements in place for safeguarding people, however not all the staff were aware of the procedures for keeping people as safe as possible when suspected abuse was reported. Safe recruitment practices were carried out.

People told us there were enough staff on duty to meet their care needs. However, the duty rotas were not up to date and did not detail how some staff were deployed and the hours they worked.

People told us that they experienced some restrictive care practices, such as not being able to have a drink after a certain time, not being able to go out a night and not having access to parts of the home during the night. People had not agreed to these restrictions and the provider had not recognised that these care practices were restrictions on people's liberty. People's ability to consent to their care and treatment had not been assessed in accordance with legislation.

People did not receive effective care because the providers did not keep up to date with good practice guidance for supporting people with mental health needs. People did not receive care and support as detailed in the providers Statement of Purpose.

People's health needs were not always monitored or managed effectively and they were at risk of not having their health needs met.

People were not always treated with dignity and respect and their privacy was not always respected.

People were not always given care in a personalised way which met their individual needs.

People were not offered or supported with activities that were meaningful to them, met their preferences and allowed them to broaden their life experiences.

There was a lack of management leadership and a lack of systems to check on the quality of care, which meant people were at risk of receiving care which was not appropriate to their assessed needs and did not follow best practice.

People lived in an environment that was well maintained and clean.

Staff received induction, training, supervision and appraisal to help them to carry out their roles.

People received enough suitable food to meet their preferences and needs.

People were asked for their feedback on the service through regular resident meetings, annual surveys and keyworker meetings. Staff worked in partnership with other health and social care professionals in managing people's mental and physical health.

We found several 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.

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.

Fire safety arrangements were not being followed and this placed people at risk in the event of a fire.

The service did not have effective arrangements for the management of medicines to protect people against the risks associated with medicines.

Risk management arrangements were not robust and this placed people at risk of receiving inappropriate or unsafe care.

The provider had arrangements in place for safeguarding people, however not all the staff were aware of the procedures for keeping people as safe as possible when suspected abuse was reported.

There were sufficient numbers of staff and appropriate checks were carried out on staff before they started work at the service.

Is the service effective?

Requires improvement

The service was not consistently effective.

People's ability to consent to their care and treatment had not been assessed in accordance with legislation.

People did not receive effective care because the providers had not kept up to date with good practice guidance for supporting people with mental health needs.

People's health needs were not always monitored or managed effectively and they were at risk of not having their health needs met.

Staff received induction, training, supervision and appraisal to help them to carry out their roles.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were not always treated with dignity and respect and their privacy was not always respected.

We saw some positive interactions where staff respected people's choices and supported a person when they were distressed.

People were involved in their care and were able to provide feedback to their keyworker.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

People did not receive a service that was fully responsive or personalised to their individual needs.

People had limited opportunities to engage in social, educational and vocational activities that met their needs.

The service had arrangements in place to deal with people's concerns and complaints.

Is the service well-led?

Requires improvement

The service was not consistently well – led.

There was a lack of management leadership and a lack of effective systems to check on the quality of care, which meant people were at risk of receiving care which was not appropriate to their assessed needs and did not follow best practice.

Systems for obtaining the views of people who used the service were in place.

The staff worked in partnership with other health and social care professionals in managing people's mental and physical health.

Rainbow Lodge Nursing 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.

The inspection was carried out on 7 and 8 September 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 the inspection we reviewed the information we held on the service including previous reports, notifications of significant events, accidents and safeguarding alerts. We also spoke with a commissioner and the local authority safeguarding team. During the inspection we observed care practice and spoke with ten people using the service. We spoke with both partners, one of whom was the registered manager, the administrator, three nurses, five care staff and the cook. We reviewed eight people's care records. We reviewed records relating to the management of the service including medicines management, staff records, audit findings and incident records. After the inspection we spoke with one healthcare professional and asked them for their views and experiences of the service.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe. We received mixed feedback on safety from people using the service. The majority of people we spoke with said they felt safe. Comments we received included "I do feel safe most of the time." "I'm safe this is my home." We received other negative comments where people told us they did not feel safe. Comments we received included "I cannot feel safe here, ever" and "I do feel safe but it varies."

People were not safe as fire safety arrangements were not always being adhered too. On the first day of our inspection night staff had locked the front door with a key. The fire safety information indicated that the front door was a designated fire exit that people were to use in the event of a fire. The night staff had difficulty in locating the keys to the front door. This meant that in the event of a fire at night people were at risk of not being able to use the fire exit as it was locked. Other staff we spoke with said the front door was a designated fire exit and that was the exit they used in their fire drills.

Although people we spoke with were happy with the way the service managed their medicines we found the provider did not always manage people's medicines safely. We looked at the storage, recording of receipt, administration and disposal of medicines and people's records in relation to the management of their medicines. A member of staff told us that a particular medicine was crushed for a person at night. Another member of staff said that it was not. We asked the person who was receiving this medicine and they confirmed it was crushed by staff at night. There were no records which confirmed that this medicine could be crushed and that the GP had agreed to this. We asked the provider to obtain written confirmation from the dispensing pharmacist that it was safe to crush this medicine. The pharmacist confirmed that the medicine was not to be crushed. The medicine in question was a slow release medicine, so crushing it meant that there was a risk that it could release all of the active ingredients at once and this could be dangerous to the person.

Where medicines were prescribed to be given only 'as required' or where they were to be used only under specific circumstances, individual when required protocols, (administration guidance to inform staff about when these medicines should and should not be given) were not in place.

We viewed the care plan for a person who experienced agitation and aggression. One instruction in the care plan was 'staff to administer PRN Clonazepam when (the person) is agitated.' There was no other information about the circumstances under which these should be administered or the gap required between doses. There was no information to enable staff to make decisions as to when to give these medicines to ensure people received these when they needed them and in way which was safe consistent. People were therefore placed at risk of not receiving these medicines safely. Medication administration records (MAR) we viewed for this person detailed that staff had recorded when they had administered 'as required' medicine and for what reason.

Risks to people's safety and welfare were not consistently identified and managed. Information we viewed and discussions with staff informed us that some people at the service displayed behaviour that challenged others, such as physical and verbal aggression. Two people told us about a person who was often aggressive and had hit other people at the service. One person said that they did not feel staff did enough to prevent this person's behaviour. Another said that this person would wander into their room and often refused to leave.

Some people's care records clearly outlined the potential risks to their safety and the plans that had been put in place to support them to keep safe. In other instances risks to a person had been identified but no effective action had been taken to reduce the risk of harm. For example, two people had been assessed as being a risk to others because they displayed behaviour that challenged the service. The instructions for staff for dealing with the behaviour were the same in each case including one to one counselling and the development of a therapeutic relationship with the person. The records indicated that staff were to identify triggers of aggressive behaviour. We did not see any detailed information about any triggers to the behaviour or how to reduce the risks of it occurring nor were there any guidelines on how to support the person or others if they became distressed. The care plans did not contain sufficient guidance for staff on the actions to take to help protect the person and others in a consistent way.

Another person had been assessed as presenting a fire risk at night due to them smoking in their bedroom. The risk assessment for the person detailed they were to be monitored hourly throughout the night. We asked to see

evidence that this was carried out. Staff told us that records of checks undertaken during the night were not made. Another person's risk assessment identified they required the support of one member of staff with their bathing due to their mobility needs. We saw the person have a shower with no support from staff. This meant that people were at risk of receiving inappropriate and unsafe care because risk management processes were not robust.

The above were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Receipts of medicines, balances carried forward from the previous cycle and disposal records were maintained. Medicine Administration Records (MAR) sheets were appropriately signed when medicines were administered, this showed that people had received their medicines as prescribed. We checked a sample of medicines and the stock balance was correct and corresponded with the quantity that had been administered. Care records we viewed detailed that people's medicines were regularly reviewed by the GP and consultant psychiatrist in response to people's changing needs. Where people required pain medicine prior to any wound dressings we saw that these had been administered.

We saw that risks of falls assessment were regularly reviewed along with an assessment of people's level of dependency, nutritional risks and risks of pressure sores. The providers and staff knew people well and were able to describe the various risks that people presented with.

We asked staff how they would recognise and report potential or actual abuse. Three of the four staff we spoke with were able to describe the various types of abuse people could be exposed to and the action they would take, if they had a concern about a person, to protect them. One member of staff did not know what action to take if they suspected abuse. We also asked staff about their understanding of whistleblowing (whistleblowing is when someone directly employed by a registered provider, or someone providing a service for the provider, reports concerns where there is harm, or the risk of harm, to people, or possible criminal activity and the management have not dealt with those concerns by discussing them or by using the employer's own whistleblowing policy, or the worker does not feel confident that the management will deal with those concerns properly and contacts a 'prescribed body', such as a regulator instead.) Two of the four staff we spoke with were not able to tell us which external agencies they would contact if they had concerns about the way the provider operated the service and the safety of people. This meant not all staff were aware of the procedures for keeping people as safe as possible when suspected abuse was reported.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training information showed that all staff had undertaken training in safeguarding. During our inspection we attended the weekly residents meeting. We were told by the providers that safeguarding was a standing agenda item for each meeting. We saw the manager starting the meeting by telling people about safeguarding and their rights. People told us they signed a book when they left the building and when they returned so that staff knew their whereabouts.

The feedback we received from people using the service and staff was that there were enough staff to meet people's needs. We observed staff attending to people in an unhurried manner and responding to people's requests.

Staff records showed the provider had recruitment procedures in place and had carried out appropriate employment checks of staff regarding their suitability to work in the home. These included evidence of relevant training, references from former employers and security checks with the Disclosure Barring Service (DBS). Staff confirmed they did not start work until all recruitment checks had taken place.

The premises were well maintained and clean throughout the home during the inspection. Regular checks were carried out on people's rooms and the communal areas for any maintenance issues and to ensure that people were safe. We looked at certificates relating to health and safety. We saw that gas, electrical and fire safety certificates were in place and renewed as required to ensure the premises remained safe for staff and people using the service.

Requires improvement

Is the service effective?

Our findings

We identified there were established care practices that affected people's ability to be able to take control and make decisions about their lives. For example, people had set times when they could make a drink. One person told us 'I cannot have hot drinks here after 9pm, there are set times before that, if they are in a good mood they will give it to you, garden doors get locked at 9.30 or 10pm'. Another person told us 'You cannot take drinks or eat in your room because they put new carpets down'. Another person said "We cannot leave at night." This meant that people's choices were limited and the care practices were not in keeping with the provider's stated aim for each person to be 'provided with and empowered to exercise choice'. The provider had not recognised that these care practices were restrictive. A member of staff said they liked to have people back at the home by 8pm in the evening and liked them not to go out during the night. They said this was for safety reasons.

The provider had not always assessed people's capacity to consent to care and treatment. They told us all the people living at the service had the mental capacity to consent to all aspects of their care and treatment. The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) state that where people are deprived of their liberty, certain processes must be followed and recorded. These include assessing people's capacity to consent to restrictions, planning to review restrictive measures on a regular basis and considering ways in which people's needs can be met in a less restrictive manner.

The provider told us about a person who had difficulty in managing their finances. This person had been assessed by the psychiatrist as having capacity to make this decision, however there was no record available which showed this. All the care records contained a consent form covering sharing of rooms, use of photographs, agreements with care plans and concerning handling of personal finance. One person's form was not clear whether they had agreed to share a room. Another person's form was signed by one of the provider's who had told us that the person had mental capacity to make decisions about their care. Although people had capacity to make decisions there was no evidence that they were fully involved in making decisions about their care and support.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked all the people who shared a room whether they had been given a choice about this and whether they were happy to share. It was not clear that people had been offered a choice as some had been at the home for a very long time. However, everyone said that they were happy to share a room.

People did not receive effective care because the providers had not kept up to date with good practice guidelines for supporting people with mental health needs. We asked nursing staff about recognised models/tools they used in supporting people. They were unable to tell us. Throughout our inspection we saw that staff ensured that people were cared for and sometimes in difficult circumstances. However, the home's Statement of Purpose (a Statement of Purpose is a document required by legislation to be provided to people to show what the service offers), referred to the provision of a therapeutic environment promoting rehabilitation. Care plans and risk assessments emphasised the nature of the therapeutic relationships required to support people. The staff we spoke with, including senior staff, did not have up to date training on therapeutic interventions with people with mental health issues. Care staff were unable to explain the nature of therapeutic processes being used within the service. Assessments which monitored people's progress in developing independence in respect of life skills were seen but staff were unable to tell us what was actually done to promote these skills. For another person we saw that no effective plans were in place to manage their agoraphobia, such as the use of cognitive behavioural therapy. Care plan reviews we saw indicated that there was no change in behaviours over long periods for some people despite this being a goal to be achieved. We concluded that staff did not have the knowledge and expertise to deliver interventions aimed at rehabilitation as stated in their Statement of Purpose and people were at risk of receiving inappropriate care and treatment.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health needs were not always monitored or managed effectively. Information in a care plan for a person that experienced urinary tract infections (UTI) detailed the person was to drink sufficient fluids to prevent the occurrence of urinary tract infection. A fluid balance chart

Requires improvement

Is the service effective?

detailing the person's fluid input and output was to be completed daily. We asked to see the charts. Staff told us that no such charts were in use. We asked the manager about this, they did not know that this had been identified as a need for the person. They told us the person drank well and the information was incorrect. Records detailed that concerns remained about the amount that the person drank and urine samples had been sent as there was a risk of the person having a urinary tract infection. For another person their records stated that they were to be referred to the bowel and bladder service because of issues regarding night time incontinence. There was no record of the referral being made. We asked the manager about this. She told us that the referral was not made because "the person did not wish to wear incontinence pads at night and therefore had refused to attend this service." There was no record of the person's rejection of the offer of the referral and no evidence that action had been taken to address a long standing problem. The person was in a shared room and staff had not considered the impact of their incontinence and malodours for the other person sharing.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other records seen showed that people had access to a range of healthcare professionals including opticians, dentists, GP and specialist nurses. Care records were completed to reflect the outcome of appointments attended and any changes to the person's care were acted upon by staff. For example, there was a change in the dose of medicine for a person. For another person they were to have daily blood glucose monitoring for the management of their diabetes and records demonstrated that this was carried out.

All staff confirmed they were supported in their roles. They said they received induction, training, development, supervision and appraisal which enabled them to carry out their roles and meet people's individual needs. They told us they had attended training on core subjects including health and safety, Mental Capacity Act 2005, moving and handling, safeguarding and managing challenging behaviour. Staff received an induction when they started work at the service. A new member of staff confirmed they had worked alongside more experienced staff as part of their induction. This helped ensure they had the knowledge they required to carry out their roles effectively before they worked alone with people. Training information confirmed the training staff had completed.

People told us they liked the food at the service. Comments from people included "The food is alright, sometimes good, sometimes bad", "the food here is good and "the food here is alright but there is not much choice but you can ask for more if you are not full." The cook explained that two options for the main meal at lunch time were offered and was able to demonstrate knowledge of some people's individual preferences such as one person who preferred an Italian diet and another who was vegetarian. We were told that special meals would be prepared for these people at their request. All the people we spoke to were happy with the meals offered. People required minimal support to eat. Staff served the meals in a respectful way and offered people the choices available. There was plenty of fresh fruit for dessert. Care records we viewed contained an information sheet which contained information on people's likes, dislikes and special dietary preferences. People's nutritional needs had been assessed and people's needs in relation to nutrition were documented in their plans of care.

Requires improvement

Is the service caring?

Our findings

We received mixed feedback from people about how caring the service was. Positive comments we received included "the staff here are kind and they do the best that they can, I have never had any problems with the staff here" and "staff are ok." Negative comments we received included "sometimes there's a bit of friction between people here and the staff, nothing serious but still, it's alright but sometimes there's arguing over amounts of food", "the staff just walk into my room without knocking in the morning and hand me my medication', "the staff just walk into my room (without knocking)."

People's privacy and dignity was not always respected. We saw some staff walking into people's bedrooms without knocking and a member of staff walk into the shower room five times when a person was bathing without knocking on the door. Two people we spoke with told us that some staff regularly did not knock or wait for a response before they entered their room although other staff did do so. We found that some staff had a dismissive attitude towards people at the service. For example, a person told the staff that they were "not feeling well", the staff member said "you will be fine" and then looked at us and said 'It's all in his mind". We were concerned that one member of staff offered us the use of a table in a person's bedroom to use during our visit to look at people's files. They showed us the room without asking the person to whom it belonged and said "X would not mind". We observed the manager was not proactive in engaging with people and did not initiate conversation when they approached her. People's confidentiality was not always maintained. We heard the manager discussing sensitive information within the communal lounge including medical and legal information in relation to a particular person.

The above examples showed us that people were not always treated with dignity and respect and their privacy was not always respected.

This was a breach of regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We observed some good and caring interactions that staff had with people, for example we saw the administrator calm a person down when they became distressed. Another person came into the office and told staff they had purchased a clock for the lounge. They were thanked and praised by the staff. When a person declined treatment this was respected and the staff member told the person they would return later to see if they had changed their mind. People made choices where they spent their time and we saw that the people felt comfortable with staff. One person said 'the staff are really ok here." Another told us a particular member of staff "worked particularly hard to the benefit of people living at the home."

People's religious needs were met, for example a person accessed the local Mosque and the Imam from the Mosque visited them at the service.

Advocacy information which contained contact details of advocacy organisations was displayed in the main entrance. None of the people at the service had an advocate at the time of our inspection, the provider said they would support people to access advocacy services if they wanted to.

People had some involvement in the development of their care plan, however it was not always clear that people or their relatives had been involved in the setting up or review of people's care plans. Nursing staff told us that care plans were reviewed monthly or sooner if a person's needs had changed, they told us that each person had a member of staff allocated to them as their keyworker. This was a designated member of staff who met with them regularly to ensure their needs were being met and to encourage them to express their views on their care. Records of keyworker sessions were maintained and these demonstrated that people were involved in their care.

Requires improvement

Is the service responsive?

Our findings

People did not receive a service that was fully responsive or personalised to their individual needs. Care plans were not always reflective of people's up to date needs and wishes. There were therefore risks that people might not receive the care they needed. For example information from a Care Programme Approach (CPA) review detailed that a person was at risk of alcohol abuse which had an impact on their mental health. No care plan was in place for this need. Where people had care plans in place regarding their mental health generic statements were written, for example 'staff to build up a good relationship' and 'monitor mental health'. For another person we saw they took their medicine in a particular way. There was no information about this in their care plan. Staff we spoke to about this were able to tell us that this was the person's preference and the best way to support them to have their medicine. The lack of comprehensive guidance and plans of care for identified needs meant that people were at risk of not receiving an individualised service.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records for a person showed they were to be reviewed by their psychiatrist in relation to repeated allegations they made. There was no evidence in the records that the review had taken place or the conclusions of it. We asked senior staff about this. The provider explained the person had been reviewed but was unable to explain the absence of a record about the review, its conclusions and whether the person was supported by their relative or other representative. This meant that people were at risk of inappropriate care as a full, accurate and up to date record was not maintained.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had limited opportunities to engage in social, educational and vocational activities that met their needs. One person told us "I usually do read books and watch television, people play cards but I don't like that, I play darts sometimes." And another said "It is quiet here, but sometimes it's simply boring." There was a large board in the dining area pictorially informing people of the activities available in the morning, afternoon and evening of each day. Various activities such as darts, walk in the garden, cards, book reading, dominoes, coffee morning, drawing, newspapers reading, magazine reading, puzzles, bingo, bar and quiz night, curry night, music and a movie were displayed. We saw no evidence during our visit of these activities being proactively promoted. The programme lacked expertise and largely failed to take account of people's individual interests. For example, a person's social and recreational care plan did not detail the person's interests in art, photography or guitar playing in their care plan. There was no evidence that art therapies had been sought for this person either in the home or in the community. For another person we saw that they liked to go fishing, there was no evidence in the care plan that staff had supported the person to undertake this activity.

People attending the residents meeting were asked to let staff know if they wanted to do anything. People said they were happy with the activities available and fedback that they had enjoyed a recent trip to Bournemouth. We asked the providers about the activities and were told that people largely did what they wanted and it was 'their choice'. We found that people were not actively engaged and spent long periods of time sitting in the lounge, in their bedrooms or smoking in the garden area with little stimulation. Training information detailed that staff had undertaking training in 'therapeutic activities'. We found that staff had little awareness of how to encourage people whose motivation was low due to their mental health issues and activities were not based on people's individual needs and preferences. Lack of appropriate and meaningful activities taking place on a regular basis could result in people becoming isolated and withdrawn.

Prior to people moving into the service pre-admission assessments were carried out by one of the providers to ascertain whether the service was suitable and able to meet a person's support needs. We saw other information was also obtained from social and healthcare professionals. Assessment information we viewed for two people showed us that people had been involved in their assessment. The nursing staff we spoke with said the provider discussed all referrals with them and whether the service could meet their needs.

Weekly resident meetings took place where people were able to have their say on any issues they had about the service they received. During our inspection we attended a

Requires improvement

Is the service responsive?

residents meeting. People were asked for their views and opinions on various aspects of the service such as safeguarding, food, activities and any other issues that they wanted raising.

People we spoke with knew who they should approach if they wanted to make a complaint. One person said "There is a patient meeting every Tuesday, if you have any concerns you can raise them there." Another said "I would feel confident to make a complaint if I had to." The home's complaints procedure was displayed in the entrance hall. The procedure clearly outlined how people could make a complaint and the process for dealing with this. Staff told us they also discussed any concerns people had during keyworker sessions.

We recommend that the registered provider seeks and follows advice and guidance from a reputable source, regarding activities provision for people with a mental health condition.

Requires improvement

Is the service well-led?

Our findings

People told us if they had any concerns they would speak with one of the providers. We saw people engaging with the provider who knew them well. The service was not consistently well-led, there was a lack of leadership and direction from the registered manager in ensuring that people received care and support based on best practice and as detailed in their Statement of Purpose, (A Statement of Purpose is a document required by legislation to be provided to people to show what the service offers).

The provider is a partnership and one of the partners is the registered manager. She was present during the inspection. The staffing rota did not show when she was on duty in the home. We saw that she attended the residents meeting and staff meetings. One to one supervision was mostly carried out by the other partner. The manager was unable to provide us with first-hand information about people at the service and referred to other staff to provide the information. Pre-admission assessments were carried out by the other partner, as were CPA reviews and medicine audits. All other audits were carried out by the administrator who told us that the results were fedback to the manager. There was no evidence the manager worked alongside staff to monitor their practice. Most of the role was being assumed by the other partner or administrator. We spoke with the manager who informed us that she was involved in all day to day decision making, but did not get involved in the "paperwork". There was therefore little that the manager was doing in relation to leading the team, assessing and monitoring the service and supporting them in delivering quality and safe care to people. Comments from staff about the manager included "She does come to the home and asks us if everything is ok." Another staff member said "She pops in for a couple of hours a day."

Systems and processes to assess, monitor and improve the quality and safety of the service or identify and manage risks to people's safety were not always effective. Our findings during the inspection showed the quality assurance system was not always effective because issues identified at the time of our inspection such as the shortfalls surrounding safety, medicines management, restrictive practices, consent, staff not using best practice guidance and lack of person centred care had not been recognised during the auditing process. This meant they were not effective in ensuring the home was well-led and people received the necessary standards of care and support.

Duty rotas were not up to date. They did not show us what shifts were worked by the manager, provider, domestic staff and the cook. From the rotas we saw that three staff carried out catering duties and two staff carried out domestic duties, we could not ascertain from the rotas on which days they were catering, cooking or caring, how they were deployed and what hours they had worked.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where the audits had identified shortfalls we saw that action had been taken. For example, a person's care plans had been updated. Mealtime audits had resulted improvements being identified in the deserts that were provided. Accidents and incidents were recorded and these were reviewed to enable patterns and trends to be identified so where possible plans could be put in place to keep people safe.

People's feedback on the service was sought so that improvements could be made. The provider carried out an annual survey of people who used the service. All completed surveys for 2015 showed people were satisfied with the service they received. Improvements had been made to the environment and people told us they were happy with the changes.

Staff had regular team meetings at which they discussed how care could be improved. The minutes of these meetings showed that staff had an opportunity to discuss any changes in people's care needs, developments in the service and training. Staff told us they could raise any concerns they had so that appropriate action could be taken. Staff said the providers were supportive.

The service worked closely with health and social care professionals specialising in the care of people with mental health needs. The provider told us they received support from the home treatment mental health team when people's mental health conditions changed or relapsed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The care and treatment of service users did not meet their needs or reflect their preferences.** **Regulation 9 (1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users were not treated with dignity and respect and their privacy was not ensured.** **Regulation 10 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place to obtain and act in accordance with the consent of people who used the service in relation to the care and treatment provided for them.** **Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not provide care in a safe way for people by assessing the risks to the health and safety of people of receiving the care and treatment and doing all that is reasonably practicable to mitigate any such risks and by not having proper and safe management of medicines and ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

Regulation 12 (1) (a)(b)(c)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not protect people from abuse and improper treatment because systems and processes were not operated effectively to prevent abuse of service users. Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not ensure that systems or processes were operated effectively to ensure compliance with the requirements in this Part. This includes assessing, monitoring and improving the quality and safety of the services provided in the carrying on of the regulated activity, assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity and maintain an accurate, complete and contemporaneous record in respect of each service user and the management of the regulated activity. Regulation 17 (1) (2)(a)(b)(c)(d)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take