

Mr. Liakatali Hasham

St Catherine's Manor

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

This was an unannounced inspection that took place on 24 November 2015.

St Catherine's Manor is registered to provide accommodation with care for up to 34 people. At the time of our visit, there were 27 people living at the home. The majority of the people who live at the home are living with dementia; some have complex needs. The home also provides end of life care. The accommodation is provided over two floors that were accessible by stairs and a lift.

At the time of the inspection there was not a registered manager in post. 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. The manager informed us they had begun the application process to become the registered manager.

Systems and procedures to manage medicines safely were not being followed correctly. There was a risk that people might not receive their medicines in a timely manner or receive the incorrect medicines. Protocols regarding the administration of covert medicines were not being followed therefore people were at risk of not

Summary of findings

receiving this type of medicine in a consistent way. Covert medicines are a practice of deliberately disguising medicines usually in food or drink, in order that the person does not realise that they are taking it. Arrangements in place to monitor staff competency in administering medicines was not robust enough.

Systems and procedures to protect people from harm were not being followed correctly. Whilst some risk assessments were in place, others were not, they were not person centred or in line with current guidelines.

We found there were not always enough staff effectively deployed to meet people's needs. This had an impact on the care and support people received.

Staff had basic understanding of Deprivation of Liberty Safeguards (DoLS), the Mental Capacity Act (MCA) and their responsibilities in respect of this. Mental capacity assessments and DoLS applications had not been fully completed in accordance with current legislation.

There were inconsistencies in the way staff responded to people's needs and information about people care and support needs were not always detailed with the correct information.

There were quality assurance systems in place, to review and monitor the quality of service provided, however they were not robust or effective at identifying or minimising risk or correcting poor practice. People told us the staff were friendly, supportive, however people had mixed feelings about the management team.

Staff did not always receive appropriate support that promoted their development. Staff we spoke with told us they had regular meetings with their line manager to discuss their work and performance. We reviewed the provider's records and noted that some staff was still awaiting their supervision and clinical supervision for the nurses had not taken place. We have made a recommendation that the provider research and implements requirements set by the Nursing and Midwifery Council regarding support for clinical staff.

People attended activities in the home and in their community; however they were not always specific to people's needs or preferences. We have made a recommendation that the provider reviews individual hobbies and interests and looks at ways these could be implemented and people supported to participate.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and were involved in the regular monitoring of their health. Staff worked effectively with healthcare professionals and were proactive in referring people for treatment.

Staff involved and treated people with compassion, kindness, dignity and respect. However people told us they felt staff morale had an impact on the care and support provided. People told us, "They are very approachable and know each person individually and I think they do a good job; but morale is low."

People's preferences, likes and dislikes had been taken into consideration. People's relatives and friends were able to visit. Staff told us they always made sure they respected people's privacy and dignity when providing personal care.

People told us if they had any issues they would speak to the staff or the manager. People were encouraged to voice their concerns or complaints about the home and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service provision.

People told us they felt safe at the home. Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place.

Recruitment practices were in place and were followed to ensure that relevant checks had been completed before staff commenced work.

Fire safety arrangements and risk assessments for the environment were in place to help keep people safe. The home had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding and power cuts.

The manager ensured staff had the skills and experience which were necessary to carry out their role. The staff team were knowledgeable about people's care needs. People told us they felt supported and staff knew what they were doing.

Summary of findings

The provider had sought, encouraged and supported people's involvement in the improvement of the home. Action taken had been recorded to make people aware of the concerns raised and how these were being addressed.

We found a number of 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 this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Medicines were not managed by staff in a safe way.

Arrangements in place to manage risks safely were not effective or robust enough.

There was not sufficient staff effectively deployed to meet people's needs. This had an impact on the care and support people received.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

Staff were trained in safeguarding adults and knew how to report any concerns. There was a contingency plan in place in case of an emergency.

Requires improvement



Is the service effective?

The service was not consistently effective.

Staff had a basic understanding of Deprivation of Liberty Safeguards (DoLS) the Mental Capacity Act (MCA) and their responsibilities in respect of this. Mental capacity assessments and DoLS applications had not been fully completed in accordance with current legislation.

Staff did not always receive appropriate support that promoted their development. However, people were supported by staff that had the necessary skills and knowledge to meet their assessed needs

People's care, treatment and support promoted their well-being and there was good communication with healthcare professionals.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk.

Requires improvement



Is the service caring?

The service was caring.

People were treated with kindness and care, respect and dignity.

Staff encouraged people to make their own decisions about their care and staff supported people to lead independent lives.

People's relatives were made to feel welcome in the home.

Good



Is the service responsive?

The service was not always responsive.

Requires improvement



Summary of findings

There were inconsistencies in the way staff responded to people's needs and information for people around their care was not always detailed with the correct information.

There were not enough activities provided for people's specific needs.

People were encouraged to voice their concerns or complaints about the home and they were dealt with promptly.

People's needs were assessed when they entered the home and reviewed regularly.

Is the service well-led?

The service was not consistently well-led.

The provider had systems in place to regularly assess and monitor the quality of the home but they were not robust or effective enough to identify and minimise risk or correct poor practice.

The provider had sought, encouraged and supported people's involvement in the improvement of the home. People's opinions had been recorded.

Requires improvement



St Catherine's Manor

Detailed findings

Background to this inspection

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

We visited the home on 24 November 2015 and it was an unannounced inspection. The inspection was conducted by two inspectors, a specialist advisor 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 service.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance team. We also reviewed records held by the Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the home is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We contacted the local authority and health authority, who had funding responsibility for people living in the home. We contacted four health and social care professionals who were involved with the home to obtain their views.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern.

During the visit we spoke with four people living at the home, 13 relatives, three care staff, two nurses, two domestic and kitchen staff, the manager and the operations director. We spent time in communal areas observing the interaction between staff and people and watched how people were being cared for by staff. We reviewed a variety of documents which included six people's care plans, risk assessments, medicines administration records and accident and incident records. We also reviewed five staff files, minutes of meetings, complaints records and some policies and procedures in relation to the quality of the service the home provided.

We last carried out an inspection to St Catherine's Manor in December 2013 and found no concerns.

Is the service safe?

Our findings

Relatives told us they felt their family members were very safe at the home and with the staff who provided care and support. People told us, “I am happy here, the staff are very open and I like that, it’s very homely.” Another person told us, “Yes I feel safer here, there was an incident but the manager has dealt with that.” A relative told us, “My relative is safe here and the staff take good care of her.” Another relative told us, “[Person] was safe and I trust the staff and the manager and I have never seen anything untoward.”

Medicines were not managed by staff in a safe way. For example, we observed staff dispensing a person’s medicines into a pot, when they approached the person, they noted the person was eating and did not want to disturb them. Staff placed the pot containing the medicines back inside the medicines trolley and returned when the person had finished eating. This is an unsafe practice, as medicines may get mixed up and administer to the wrong person.

Staff did not follow best practice when administering medicines by minimising the disruption to the medicines rounds. Staff were interrupted during the lunchtime medicines round by other members of staff. This demonstrated that people were not only at risk of not receiving their medicine on time but also at risk of receiving another person’s medicine by mistake.

Stocks of medicines were not always managed in a safe way. For example, large quantities of medicines were stored for some people. One person had six boxes of PRN (as required) medicines in the stock cupboard. Another person had four new bottles of medicine. Both medicines had a variety of dates on them. This indicated staff were not checking stock levels prior to ordering new medicines which posed the risk of over-stocking medicines unnecessarily.

Storage of medicines was not managed in a safe way posing a risk to people. People could gain access to the room where medicines were stored. Although they could not access the medicine trolley they could access other items such as scissors, syringes, and dressings which were stored in unlocked cupboards.

There was not a robust system in place to monitor and review staff’s competency in administering medicines. We were told only staff who had attended training in the safe

management of medicines were authorised to administer them. Staff had attended regular refresher training in this area and after completing this training, the manager observed staff administering medicines to assess their competency before they were authorised to do this without supervision. However, we noted that not all of the staff had received a recent medicines competency assessment.

The medicines administration records (MAR) recorded when medicines were administered. A medicines profile had been completed for each person, and any allergies to medicines recorded so that staff knew which medicines people received. A photograph of the each person was present to ensure that they were giving the medicine to the correct person. We noted that PRN [as needed] medicines information was included, but any medicine refused was not being documented and the reason why. All medicines coming into the home were recorded and medicines returned for disposal were recorded in a register.

People who were given covert medicines were not always administered in a consistent and safe manner. The administration of Covert medicines is a practice of deliberately disguising medicines usually in food or drink, in order that the person does not realise that they are taking it. We noted that there no information provided about why the medicine was required to be given in this form. There was no evidence of the covert medicine being discussed with a Pharmacist. For example some medicines are not allowed to be crushed or a capsule opened to enable medicines to be placed in food or drink. This demonstrated that people could be at risk of receiving covert medicines in a form that they are not licensed to be used.

Medicines policies and procedures were in place to guide and inform staff. These included policies on as and when required medicines (PRN), controlled drugs and medicines errors. However these were not always followed by staff.

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

People told us staff supported them to receive their medicines. A relative told us, “My [person]’s medication has been reduced since she came in and she has gone from strength to strength and now only takes one tablet.” When staff administered medicines to people, they explained the medicine to them and why they needed to take it. Staff

Is the service safe?

waited patiently until the person had taken the medicine. Staff knew the importance of giving medicines on time and the reasons why this was important to reduce the risk of side effects. Any changes to people's medicines were prescribed by the person's GP.

Risks to people had not always been managed safely so staff were not following current guidelines to identify and monitor risks. We noted that risk assessment specific for the building were in place but were not up to date and it had not been reviewed since 2014. People's care records included assessments for mobility, hygiene, social interaction, and behaviour that may challenge. Some risk assessments were not in place. For example, where people were at risk of malnutrition current guidelines such as a Malnutrition Universal Screening Tool (MUST) were not in place. MUST is a screening tool to identify adults at risk of malnutrition or obesity. Risk assessments for people who were at risk of choking or developing pressure sores were also not in place. People who need repositioning in their beds to prevent or alleviate pressure were not turned on a regular basis or moved from their bed to a chair. This demonstrated that people were at risk of developing or increasing the severity of existing pressure sores.

Failing to assess the risk to the health and safety of people was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt there was sufficient number of staff. Relatives had mixed comments about staff responding to call bells. A relative told us, "The call bell is not always answered quickly and when they are short of staff it's a lot longer." However, another relative told us, "My [person]'s never had to complain about having to wait for her call bell to be answered." During our visit we saw how the deployment of staff had an impact on the care people received. There were inconsistencies in how long people had to wait for staff to assist them. We noted that people who were situated in the communal areas were responded to more quickly than those who were in their rooms. For example, one person waited two hours before staff got them up. This demonstrated that some people were not supported to get their care needs met by staff in a timely manner.

The manager said that there should be a minimum of two nurses and five care staff on duty during the day as shift patterns vary from 8am to 2pm or 8am to 8pm. The registered manager told us absences or vacancies would

be covered by agency staff. The home used the same agency staff to ensure that there was a consistent staff team who knew people's needs and wherever possible would reduce people's anxiety at meeting new staff. The manager informed us that the staffing rotas were based on the individual needs of people. This included, supporting people to attend appointments and activities in the local community.

We reviewed the staffing rotas over a four week period and noted that on three separate occasions there were under the minimum staffing levels for nurses as calculated by the manager to keep people safe. We noted that during part of our visit there was only one nurse on duty as the other nurse was conducting an assessment visit.

Failing to have sufficient numbers of staff deployed in order to meet people's care and support needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safety arrangements for people were in place in the event of an emergency. Fire safety arrangements and risk assessments for the environment were in place to help keep people safe. Each person had an individual personal evacuation plan (PEEP) in place and staff carried out regular fire drills and evacuations so they knew what to do in the event of a fire. The home had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding and power cuts. The provider had identified alternative locations which would be utilised if the home was unable to be used.

We saw accident records were kept which contained a description of the accident, time it occurred and if people required hospital treatment. Each accident had an accident form completed, which included immediate action taken. There was no summary of identifying trends and patterns. This demonstrated that there were no arrangements for monitoring trends or patterns to minimise the risks of events or prevent reoccurrences of accidents or incidents.

Staff confirmed they had received safeguarding training and they were aware of their responsibilities in relation to safeguarding adults at risk. Staff were able to describe the different types of abuse and what might indicate that

Is the service safe?

abuse was taking place. For example, one member of staff said, "If I suspected abuse, I would immediately report it to the manager or nurse in charge, I know they would file a report with the safeguarding team."

The home had the most recent Surrey County Council (SCC) multi agency safeguarding policy. This provided staff with guidance about what to do in the event of suspected abuse. We saw incidents and safeguarding had been raised and dealt with and notifications had been sent to CQC in a timely manner.

There was a staff recruitment and selection policy in place. All applicants completed an application form which recorded their employment and training history. The

provider ensured that the relevant checks were carried out as stated in the regulations to ensure staff were suitable to work with adults at risk. Staff did not commence employment until satisfactory criminal records checks and references had been obtained. During the visit not all of the staff files included a recent photograph, written references and a Disclosure and Barring System (DBS) check. However immediately after the visit the manager provided us with this information. DBS checks identify if prospective staff had a criminal record or are barred from working with people who use care and support homes. All new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

Is the service effective?

Our findings

Staff had a basic understanding of their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. People should be enabled to make decisions themselves and where this was not possible any decisions made on their behalf should be made in their best interests. We reviewed the provider's records and saw that staff had received training in the MCA and DoLS.

Documentation that recorded information about people who had medicines administered covertly was not fully completed. For example, no information was provided about why the medication was required to be given in this way. The administration of Covert medicines is a practice of deliberately disguising medicines usually in food or drink, in order that the person does not realise that they are taking it.

People who lacked capacity were not fully protected and best practices were not being followed in accordance with the MCA. The manager told us that there were some people who lacked mental capacity. Mental capacity was not routinely assessed or considered and action taken when a person was found to lack capacity. There was no record on people's files that demonstrated a person did not have capacity to consent or that showed who had legal responsibilities to make decisions on their behalf. For example where people were given medicines covertly there was no information about a best interest meeting to discuss what should happen in the person's best interest and who should make that decision. The Care Quality Commission (CQC) monitors the operation of the DoLS which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. DoLS applications had not been fully completed or submitted to the local authority in accordance with current legislation. For example, people who had bed rails or used wheelchair belts could be having their liberty restricted.

Failure to meet the requirements of the Mental Capacity Act 2005 and associated code of practice was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff ensured they obtained people's consent before providing care and support in accordance with their wishes. We observed that staff sought people's agreement before supporting them and then waited for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions.

People's care plans contained forms which detailed that consent had been obtained in certain aspects of people's care. For example, in relation to administering medicines or for people who did not want to be resuscitated in the event of a medical emergency.

Staff did not always receive appropriate support that promoted their development. Staff we spoke with told us they had regular meetings with their line manager to discuss their work and performance. The manager confirmed that supervision and annual appraisals took place with staff to discuss issues and development needs. However, we reviewed the provider's records and noted that some staff were still awaiting their supervision and clinical supervision for the nurses had not taken place. This demonstrated that care staff and nurses did not all receive regular supervision or clinical support relevant to their role and responsibilities.

We recommend the provider undertakes research and implements requirements set by the Nursing and Midwifery Council in relation to support for clinical staff.

People told us about the food at the home. One person told us, "There are always snacks and drinks on hand." A relative told us, "[Person] enjoys the food and she gets a choice." They went on to say, "They do a wonderful spread at Christmas." Another relative told us, "The food is good; they are very conscientious about nutrition and drink." The chef prepared and cooked all of the meals in the home. People were involved in the consultation about the choice

Is the service effective?

of menu for breakfast, lunch and tea. There was a choice of nutritious food and drink available throughout the day; an alternative option was available if people did not like what was on offer.

Information provided by healthcare professionals was not always integrated into practice. For example people on textured food, was given 'Individual Liquidised' that resembled 'mousse or yoghurt'. There was no information about the type of textured food they should have which is in line with the National Texture Modified Diet Classifications. This identifies different types of textured food including a description. This demonstrated that people could be at risk of choking if they do not eat the correct textured food. The chef confirmed that the Speech and Language Therapy (SaLT) team were involved with people who had special dietary requirements.

Lunchtime was a very quiet occasion. People were able to choose who they sat with and some people had their lunch together in the dining room, communal lounges or in their room. However there was a limited amount of interaction such as conversation between staff and people during

lunchtime which affected the atmosphere at lunchtime. Detailed information about people's food likes and dislikes and preferences such as religious or cultural needs was available.

There were qualified, skilled and experienced staff to support people living at the home. The manager ensured staff had the skills and experience which were necessary to carry out their roles. Staff confirmed that a staff induction programme was in place. One member of staff said, "I attended safeguarding, health and safety, infection control, manual handling, mental health awareness, and MCA and DoLS training." We found the staff team were knowledgeable about people's care needs. Training was provided during induction and then on an ongoing basis. Staff said that they received training that helped them care for people and meet their needs.

People had access to healthcare professional such as doctors, district nurses, psychiatrists, and other health and social care professionals. One person told us, "I have seen the optician and now I have a pair of glasses, I also have seen the dentist and the doctor visits regularly." People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in their care records.

Is the service caring?

Our findings

People told us staff were kind and caring. A person told us, “The carers are alright and they are pleasant.” A relative told us, “They are very approachable and know each person individually and I think they do a good job; but morale is low.” Another relative told us, “The carers care but there could be more interaction.” Another relative told us, “They look after him the way I would want him looked after; they know him off by heart.”

Staff showed kindness to people and interacted with them in a positive and proactive way. We observed a member of staff gently supporting a person to walk. This was conducted at the person’s own pace and the member of staff talked and encouraged the person throughout the task.

People made choices about when to get up in the morning, what to eat, what to wear and activities they would like to participate in, so they could maintain their independence. A person told us, “I can get up when you want to.” People personalised their room with their own furniture and personal items so that they are surrounded by things that were familiar to them. People had the right to refuse treatment or care and this information was recorded in their care plans. Guidance was also given to staff about what to do in these situations.

Staff knew the people they supported. Staff were able to talk about people, their likes, dislikes and interests and the care and support they needed. There was information in care records that highlighted people’s personal preferences, and what support was required so that staff

would know what people needed from them. Information was recorded in people’s plans about the way they would like to be spoken to and how they would react to questions or situations. Staff knew people’s personal and social needs and preferences from reading their care records and getting to know them.

Staff approached people with kindness and compassion. A relative told us, “Staff are very caring, I have no worries about the care she is receiving.” We saw that staff treated people with dignity and respect. Personal care was provided in private. Staff called people by their preferred names. Staff interacted with people throughout the day, for example when supporting them throughout the home, attending activities in the home, listening to music and watching television. At each stage they checked that the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner.

People were involved in making decisions about their care. We observed that when staff asked people questions, they were given time to respond. For example, when being offered drinks or food. Staff did not rush people for a response, nor did they make the choice for the person.

People were protected from social isolation with the activities, interests and hobbies they were involved with. Relatives and friends were encouraged to visit and maintain relationships with people. People confirmed that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres. We also saw that religious services were held in the home and these were open to those who wished to attend.

Is the service responsive?

Our findings

Staff were inconsistent in the way they responded to people's needs. We observed examples of inconsistencies in the way staff responded to people's needs.

The care plans we reviewed recorded people's care and support needs in relation to communication, mental health and activities. Information included people's interests, tissue viability, personal care, eating and drinking, continence and strengths.

Care records held information which identified individual's care and support and any changes to people's care was updated in their care record, however the information recorded was not always up to date or in accordance with people's care needs. For example one person's records stated that their skin was intact, however staff informed us that the person had a grade 2 pressure sore. This showed us that staff's knowledge of people's needs did not match what was written in people's care notes, therefore any member of staff who did not know the person might not be providing care and treatment in accordance with their needs.

Although care plans were completed there were inconsistencies in the way the information was recorded as it did not reflect what was recorded on the computer system or vice versa. This showed us that new or agency staff who did not know people might not be working to the most up to date information. For example, where pictures had been taken of pressure sores, there was no information of the actual size of the wound, which would provide information about the progression of the wound. This meant that there was not always up to date information about people's wound care management.

Information held about people was not person-centred. Daily records were completed to record support provided to each person; however these were written in a task orientated way. There was no information about people's interactions, activities or mood. This showed us that although there was information about the support provided, the information was not focused on the person's care or support needs in accordance to their preferences.

People confirmed they were involved in the planning and delivery of their care. Care records were reviewed regularly

and any healthcare visits, treatment given and instructions to staff were noted. We noted that not all outcomes of people's visits to healthcare professionals were recorded in their care records.

As care and treatment was not always provided appropriate to the needs of people was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who knew their care and support needs. Staff told us, "I would get to know someone by talking to them, reading their care plan, asking staff and their relatives." They said any changes in someone's needs were reported to the senior to action, but all staff were responsible for keeping care plans up to date.

People received care that was based on their individual needs. Although some current information was not recorded, staff were knowledgeable about people's needs. Assessments were carried out before people moved into the home and then reviewed once the person had settled in. Details of health and social care professionals involved in supporting the person such as their doctor and or care manager were recorded. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded.

People were provided with the necessary equipment to assist with their care and support needs. We saw items such as lifting equipment, wheelchairs, bath seats, specialist mattresses and beds and talking items such as a clock for people with a sensory impairment.

People confirmed they took part in the activities in the home. One relative told us, "They have been to Southsea, visited the funfair and they have a musician come in; there was also a miniature pony that they brought in, they do the best they can." Another relative told us, "Yes there are a few activities and entertainment and one of the carers does take [person] outside occasionally." People also confirmed that friends, relatives and people from the local community visited them at the home. Activities consisted of art and crafts, 'pet therapy' and regular sessions with a musician where people could sing along. There was an activities programme which was displayed throughout the home and each person received a copy in an appropriate format.

However, we found there was no physical stimulation around the home for people that would provide them with

Is the service responsive?

something to do during the day when organised activities were not happening. There were no areas in the home that could create sensations to assist people living with dementia, sensory impairment or complex needs with relaxation.

We recommend that the provider reviews individual hobbies and interests and looks at ways and means of these being implemented to support people to participate.

People had their comments and complaints listened to and acted upon. People were aware of the complaints system and told us that they knew what to do if they needed to make a complaint. There were various ways that people could voice their opinion about the home. For example,

discussing issues with staff, the manager or area manager. We looked at the provider's complaints policy and procedure which was displayed at key points around the home. When people first moved in there was a copy provided in the resident's guide which people kept in their rooms. The manager maintained a complaints log and we read complaints were dealt with in a timely manner, in accordance with the complaint policy. We noted that there were eight complaints made in the last twelve months.

Staff told us they were aware of the complaints policy and procedure as well as the whistle-blowing policy. Staff knew what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously.

Is the service well-led?

Our findings

People told us the home was, “Welcoming, caring, the staff are brilliant; the nursing care is excellent.” And, “It is a very pleasant happy atmosphere, clean and hospitable.” However the systems and arrangements that were in place to monitor the quality of the service and ensure safe practices were not always robust or effective. For example where audits had identified issues with best practice, these had not been acted upon.

There was a lack of good management oversight of best practices, although management observed staff in practice and any observations were discussed with them. For example we observed poor practice taking place regarding the management of medicines and some lack of understanding regarding the grading of pressure sores. This demonstrated that the arrangements in place to observe staff’s practice techniques, was not robust enough to stop poor practices from taking place and putting people at risk of harm.

People’s care and welfare was monitored to make sure their needs were met within a safe environment. However the systems in place to make sure staff assessed and monitored its delivery of care did not take place in accordance with the provider’s policy. For example, where maintenance inspection of the home should take place on a monthly basis, the last entry was dated 6 January 2015. Monthly room checks were last conducted on 10 March 2015. We saw various audits carried out such as care plans, medicine administration records, health and safety, room maintenance and housekeeping. However, where actions or issues had been identified; they had not been followed through. For example medicine administration records not completed correctly regarding PRN medicines and some medicine competency assessments for staff were out of date.

The lack of effective quality monitoring was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, “The manager takes his job seriously, he has made a lot of changes and problems have been resolved.” The staff we spoke with us that managers were open and approachable and that they could discuss any issues they had with them. There was an open door policy and we saw people come into the office to share information, concerns or if they required assistance.

People were involved in how the home was run in a number of ways. People told us, “There are resident’s meetings.” We noted that there were residents and relatives meetings for people to provide feedback about the home. We reviewed minutes of the meeting held on 9 October 2015, where people discussed issues regarding staff recruitment, repairs to the lift and the patio area as well as up and coming improvements such as flooring and ceiling hoists.

Staff told us that team meetings were held regularly and that they could raise any concerns they had at these meetings. We reviewed minutes of the meeting held on 18 November 2015, where staff discussed issues regarding training targets, staff’s knowledge and understanding and code of conduct.

We looked at a number of policies and procedures such as environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing. The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated that they were knowledgeable about aspects of this guidance.

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12(1)(2) (a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

The registered provider had failed to assess the risks to the health and safety of people.

The registered provider had failed to ensure the proper and safe management of medicines.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

The registered provider had failed to ensure sufficient numbers of staff deployed in order to meet people's care and support needs.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

The registered provider had failed to follow legal requirements in relation to consent.

Regulated activity

Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

The registered provider had failed to provide care and treatment appropriate to the needs of people.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance

The registered provider had not ensured good governance in the home.