A. Welcome House Limited

# Kathryn's House

## Inspection report

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21 April 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Inadequate** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

The inspection took place on the 18 and 21 April 2016 and was unannounced.

Kathryn's House provides accommodation and personal care for up to 29 older people, some of who may be living with dementia. At the time of our inspection there were 26 people living at Kathryn's House. The home is set over three floors with access to the upper floors via a small lift.

There was a registered manager in place. 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.

Where risks were identified suitable risk assessments and control measures had not been implemented. Unsafe moving and handling practices were used and people did not receive support and reassurance during times of high anxiety.

Effective infection control systems were not in place and guidance was not available for staff. The home had a policy in place regarding safe laundry processes. However this was not followed and laundry procedures put people at risk of infection. The home was clean and maintained to a good standard.

Safe medicines processes were not always followed. Protocols were not in place for the administration of 'as required' medicines and unsafe administration practices were observed. People received their medicines according to the prescribed guidelines and medicines were stored securely.

Staff did not understand their responsibilities under the Mental Capacity Act (MCA) and had not received training in this area. We saw no evidence of mental capacity assessments in people's care files. The registered manager told us they were aware this was an area which required work.

Staff had not received effective training to undertake their roles and responsibilities. There were a large number of gaps in training records. Staff received supervisions in groups and did not meet with their manager individually to assess their progress and skills.

People were not always supported with their food in a safe way and people did not have a meaningful choice of food or drinks. The food provided looked appetising and portion sizes were good.

People were not supported in a caring and respectful manner. We found that people were being woken and supported to get ready for the day at an unreasonable time. People did not receive appropriate care with regard to their continence needs and continence aids were not provided at night. This meant people were left in wet and soiled beds until staff next checked if they required support.

Staff did not always speak to people in a caring and respectful manner although we also saw some positive interactions between people and staff where care was provided in a gentle and reassuring way.

Care plans were not completed in a timely and effective way. A number of people did not have care plans in place and plans were not adapted when people's needs changed.

People did not have access to a range of activities in accordance with their individual needs and preferences. Relatives told us they would like to see more activities for people.

The service did not undertake regular audits to monitor the quality and effectiveness of the service and there was a lack of managerial oversight. Relative satisfaction questionnaires were completed annually although action plans were not implemented to ensure comments were acted upon. Records within the service were not always accurately maintained.

There were sufficient staff deployed in the home. Appropriate recruitment checks were undertaken when new staff were employed to ensure they were suitable to work with people living in the service.

People were supported to maintain good health as they had access to relevant healthcare professionals when they needed them.

People's privacy was respected. Staff were seen to knock on people's doors before entering and personal care took place in private areas.

There was a complaints policy in place and relatives and people told us they would speak to the manager if they had any concerns.

People and their relatives spoke highly of the registered manager and staff team. Relatives told us they were able to visit at any time and were always made to feel welcome.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

During this inspection 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 the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Risks to people's safety and well-being were not always identified and monitored.

Unsafe moving and handling techniques were routinely used by staff which put people at risk of harm

Systems were not in place to ensure people were protected from the risk of infection.

Medicines were not always managed safely although people received their medicines according to the prescribed guidelines

There were sufficient staff deployed to keep people safe and safe recruitment systems were in place.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Systems were not in place to protect people's rights in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Systems were not in place to ensure that training was monitored effectively.

People enjoyed the food provided. However, assessed risks to people's health were not always considered when preparing food and choices were not always offered in a manner appropriate to people's needs.

People were supported to access health professionals and outcomes were recorded.

### Is the service caring?

**Inadequate**

The service was not caring.

People were woken at an unreasonable time and personal care

needs were not met in a dignified way.

People were not always spoken to in a respectful manner although we saw some interactions which were positive and kind.

People were not involved in planning and reviewing the care they received.

People's privacy was respected.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans were not all completed and were not personalised to the individual.

People did not have access to a range of activities in line with their personal needs and interests.

Complaints procedures were in place and people and relatives felt they could approach the registered manager with any concerns.

## Is the service well-led?

**Inadequate**

The service was not well-led

There was a lack of managerial over-sight of the service.

There was no evidence that regular audits were undertaken to monitor the quality and effectiveness of the service. There was no system in place to show the service had identified areas which required improvement.

Accurate records were not kept of the care provided.

Staff told us that they felt they could raise concerns with the manager and felt supported in their role.

# Kathryn's 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 took place on 18 and 21April 2016 and was unannounced. The inspection was carried out by three inspectors.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

We talked to 12 people who lived at Kathryn's House and observed the care and support provided. We spoke to four relatives, the registered manager and five staff members during the inspection.

We looked at a range of records about people's care and how the home was managed. For example, we looked at seven care plans, medicines administration records, risk assessments, accident and incident records and complaints records. We viewed four staff files, training and supervision records.

We had not asked the provider to complete a Provider Information Return (PIR) on this occasion as we brought forward out inspection in response to information we had received about the service. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The service was last inspected in November 2013 when there were no concerns.

Inadequate

# Is the service safe?

## Our findings

People and relatives told us that they felt they were safe living at the service. One person told us, "I've been here for over a year and I free safe". One relative told us, "I think he is safe."

Despite these comments we found that risks to people's safety and well-being were not always identified and effectively managed. Risk assessments were available in people's care files although these were generic and not completed in a person centred manner. Not all risks to people had been identified and guidance for staff in how to minimise risks was not always available. For example, one person had a risk assessment in place for personal care and dressing. The control measures to minimise risk to the person stated, 'Assistance of one or two carers depending on mood.' There was no clear information regarding what the risks to the person were and how staff should support the person to minimise these.

Risk assessments identified a number of people as requiring support with moving and handling and mobility. During the inspection we observed staff using unsafe procedures during transfers or when helping people to stand. We observed staff members placing their arms underneath the people's arms when assisting them to stand. This is known as a 'drag' lift and puts the person and staff members at risk of injury. The Royal College of Nursing provides the following guidance about the use of this lift technique, 'Unless there is an emergency (needing immediate action to avoid serious harm to a patient's health) drag lifts must not be carried out.' This lift technique was routinely used by staff and we did not observe staff using hoists or other equipment to support people during the inspection.

We observed one person being woken up from a deep sleep to move into the dining room. They were not given time to wake up properly before staff drag lifted them and transferred them into a wheelchair. The person looked dazed and confused and there were no foot plates on the wheelchair so the staff member tilted them backwards to move them to the dining area. On another occasion we saw a staff member pushing someone in a wheelchair without footplates so their feet were dragging on the floor. This presents a risk of injury to the person's lower limbs. Later in the day the person was moved again and the wheelchair tilted back leaving their legs unsupported. This meant that they were at risk of injury as a result.

Another person's care file stated they were unable to weight-bear and required the use of a hoist for all transfers. During the second day of our inspection we observed the person being lifted from a wheelchair to a dining chair by two staff members. One staff member lifted the person under their arms and the second staff member lifted the person's legs. This method of transfer again puts the person and staff members at risk of injury. There was a hoist positioned in the person's room although we found the battery was not charged and had therefore not been used to transfer the person from their bed to their wheelchair. No other hoist was available for use on that floor of the building.

Staff did not always support people appropriately with their anxiety and behaviours which challenged others. One person became anxious at lunchtime and began being verbally abusive towards another person sat at the same table which caused them to become distressed and appear confused. Staff ignored this situation and did not offer reassurance to either of the people involved until we asked if the person could

move to a different table.

People were not always supported to eat and drink in a safe manner. The registered manager told us prior to moving into the home, one person had been assessed by the Speech and Language Therapy Team as requiring a soft diet with pureed or minced meat. As the person was refusing to eat and losing weight the manager had offered the person food of a fork mashable consistency and they had begun to eat their meals. The person's care file did not contain guidance for staff on how to support the person safely with their food although guidance was displayed in the kitchen regarding how meat should be prepared. The registered manager was able to describe in detail how the person's food was prepared, however, there was no risk assessment in place regarding the decision to offer the person food which was not in line with professional guidance.Following the inspection the registered manager provided evidence that this issue had been addressed with the local authority and appropriate action taken.

People were at risk of receiving unsafe care as staff were not provided with information about people's needs and how their care should be provided. Care plans were not completed for some people and not all care plans in place had been regularly updated. We viewed a number of care files which did not contain care plans to guide staff in how to care for the person. The registered manager told us there were approximately six people who did not have a care plan in place as they were behind with paperwork. Two people's care files we viewed which did not contain care plans showed they had lived at the home for over six months. The registered manager told us that reviews of care plans were completed on a monthly basis although added that they were currently behind with completing them. This meant that staff did not always have the most up to date information regarding people's care. This lack of recorded and personalised care planning had an impact on people as we observed that staff were getting people up at an unreasonable time against their preferences and their continence was not being managed appropriately.

Personal Emergency Evacuation Plans (PEEPs) were not completed to guide staff and emergency services on the support people would require to leave the building in an emergency. The registered manager told us they were aware that a system was required and were currently looking at the most effective way to implement this. This meant that people were at risk of not being supported to leave the building in a safe and timely manner in the event of an emergency.

Risk assessments within some people's files identified risks and had appropriate control measures in place. For example, where people had been assessed as being at risk of falls, sensor mats had been provided meaning that staff were alerted when people may require support.

The risks of infection control were not being managed safely. The provider was not following recommended guidance in protecting people from the risk of infection. There was a policy in place which stated that soiled washing should be placed in a red soluble bag without prior sorting. We found that this policy was not being followed. There were no red soluble bags available for use and soiled washing was kept in large plastic containers in the laundry room and were not separated from un-soiled items. There were no disposable gloves available in the laundry room. The registered manager told us they had informed staff to use reusable rubber gloves when dealing with laundry as these were more substantial. This posed a further risk of cross contamination with un-soiled laundry. The registered manager told us that they did not believe these measures were necessary as the home did not provide nursing care.

There was no guidance available to staff regarding the temperatures for washing soiled items and as a result staff were unclear about how to clean soiled items. The provider's policy stated that all soiled items should be washed on a hot wash however one staff member told us that all items were washed on a warm wash. Another staff member told us that soiled sheets were laundered on a hot wash and soiled duvet's and

clothes on a warm wash. We observed soiled duvet's being warm washed which meant there was a risk of infection.

The majority of staff had not attended infection control training. The local authority had received concerns regarding infection control procedures at the home. In response the home had provided a copy of their last infection control audit dated April 2016. There was no evidence available that infection control audits had been completed prior to this date.

People were not receiving safe, appropriate care as staff had not received mandatory training to enable them to meet people's needs. Systems were not in place to ensure that training was monitored effectively and not all staff had attended mandatory training. The registered manager told us they did not have an overview of the training completed by staff as records for training were kept in the provider's office. Following the inspection the registered manager sent us details of staff training which showed gaps in mandatory training. which included areas such as safeguarding, moving and handling, Mental Capacity Act and infection control. This confirmed our findings as we found that some staff were not aware of their responsibilities in relation to these areas.

Safe medicines management processes were not always followed. We observed people being supported to take their medicines. On two occasions people's medicines were left in a pot on the dining room table unattended. On one occasion the person moved to another table and the medicines were left on the original table. This meant there was a risk that someone would take medicines not intended for them. During the second day of our inspection we observed three people say they would take the medicines later. These were returned to the medicines trolley in individual medicines pots. They were not labelled to identify who each pot belonged to which meant people were at risk of being given the wrong medicines. On another occasion we witnessed staff drop a person's tablet on the floor and then proceed to give it to the person rather than disposing of it and dispensing another dose.

There was no guidance for staff regarding how or when PRN (as required) medicines should be administered. This meant that people were at risk of not receiving PRN medicines when they required them.

The lack of effective risk management systems, staff training, effective care planning, infection control measures and safe medicines management to protect people was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines records were up to date which meant staff would know when people had received their medicines. Each person had a medication administration record (MAR) which stated what medicines they had been prescribed and when they should be taken. MAR's included people's photographs and there was a signature list to show which staff were trained to give medicines. We found no signature gaps in relation to people's MAR's and we observed staff waiting to see people had taken their medicines before signing the MAR. This meant people had been given their medicines when they required them.

The medicines trolley was locked at all times between use. There was documented evidence of destroyed and returned medicines as well as stock checks undertaken. Staff had access to a medicine policy providing guidance on the safe administration, handling, keeping, dispensing and recording of medicines. However, this was not consistently being followed.

Staff were unable to demonstrate an understanding of their safeguarding responsibilities. Training records showed that not all staff had completed safeguarding training whilst being employed at the service and some staff had not completed safeguarding training since 2010. One staff member was unable to

understand and respond to our questions in relation to safeguarding. Two staff members were able to describe the action they should take if they thought someone was at risk or being harmed or abused. Despite this we found that staff were unable to demonstrate an understanding of their learning as institutional practices which were not being recognised as potentially harmful for people continued unchallenged.

The failure to ensure systems and processes were in place to protect people from potential abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient staff on duty to meet people's needs. A relative told us they felt there was enough staff and that at times they saw staff sit and talk to their family member. The registered manager told us that they did not use a dependency tool to assess the staffing levels required but as they worked closely with staff were able to assess when additional support was required. They told us that staff all lived locally and were able to cover shifts at short notice which meant that agency staff were rarely needed. The registered manager told us there were five care staff on duty in the morning and four in the afternoon. In addition there were two waking care staff at night, a cook, kitchen assistance and domestic support daily. Records of staffing levels showed that these levels were consistently met. Staff told us they felt there were enough staff to meet people's needs although they would value more time to be able to sit and talk to people. We did not see people having to wait for care during the inspection.

Staff recruitment records contained the necessary information to help ensure the provider employed staff who were suitable to work at the home. Staff files contained a photograph, interview records, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if a prospective staff have a criminal record or are barred from working with people who use care and support services.

People were cared for in a clean and safe environment as the home was well maintained. Fire checks were completed regularly to ensure that equipment was in good working order, staff knew how to respond to a fire, and emergency evacuation plans were displayed.

Requires Improvement

# Is the service effective?

## Our findings

People and relatives told us they felt staff had the skills and experience to support people's needs. One person said, "The staff are lovely, they seem to know what they're doing." One relative told us, "I'm not sure if the Home was experience with my relative's condition but we are happy so far"

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 are called the Deprivation of Liberty Safeguards (DoLS).

People's legal right had not always been protected. The registered manager told us that the majority of people cared for at the home were living with dementia and lacked the capacity to make decisions relating to their care. However, the home did not have systems in place to assess people's capacity to make individual decisions and no mental capacity assessments had been completed. The registered manager told us that where people where referred from hospital they used the capacity information obtained from the hospital. There was no evidence available in people's care files of discussions with hospital staff regarding people's capacity. Records were not in place to evidence people had consented to their care at the home. This meant that people were at risk of not being involved in decisions which may affect their lives. The registered manager acknowledged this was an area the service needed to work on.

Staff did not have an understanding of the MCA. One staff member we spoke to was able to describe some elements of the MCA, two other staff members were not. Training records showed that only the manager and one staff member had attended MCA training. This training had not led to an understanding or appropriate actions being taken to protect people using the principles of the MCA. Staff members did not always gain consent before providing care. On a number of occasions we saw people were moved from their chairs without being told where they were going or what was about to happen. On other occasions we saw that staff took time to seek people's agreement and discuss what was going to happen next.

External exits of the home were all locked and the registered manager told us that most people would not be able to go out without staff support although there were no capacity assessments in place to support this. There was no evidence available to show that best interests meetings had been held with regard to exits being locked and DoLS applications had not been made for those subject to these restrictions. During the inspection we observed that two people accessed the community independently. However, capacity assessments had not been completed to assess this decision.

The registered manager was unable to demonstrate an understanding of the MCA and DoLS process. Records showed that one person had a DoLS in place. The registered manager explained the person had moved from a different home with the DoLS already in place so had been reassessed. One other DoLS

application had been made as again the person had moved from hospital with a DoLS in place. It was not clear from the application what restrictions were in place and why the application was being made. The registered manager said they were unsure why the application was required; they had completed it as the hospital had advised them they were required to do so.

People's human rights could be affected because the requirements of the MCA were not always followed. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not receive effective support to carry out their role. Some staff told us they had regular supervision with the manager whilst others said this was not the case. Staff said they felt they were supported by the registered manager and were able to discuss any concerns. The registered manager told us they were aware that staff supervisions were not up to date. In the six months prior to the inspection the registered manager told us that four group supervisions had taken place. There had been no one to one supervision held during this time which meant that staff's individual performance and skills had not been formally reviewed.

Failing to ensure that staff receive effective support to carry out their role was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not offered a choice of food and drinks in a way which was appropriate to their needs. The menu showed that a choice of meal was available. However, people were not shown or told about the options available to help them to make a choice. We observed that most people had their lunch brought to them and staff did not explain what the meal was. Everyone was given the same juice at lunchtime with no choice offered. One person told us they had an interest in different wines and would like a glass with their meal. Staff told us this was not something which was available to people. At breakfast people were all served the same jam on their toast without being asked if this was what they wanted.

Support at lunchtime was not provided in an organised manner. A number of people required support to eat their meals. We observed that staff were moving between tables supporting people which meant some people were sat with their meal waiting for staff to return. People were generally supported to eat at an appropriate pace although we observed one person being rushed with their meal and not being given time to swallow their food. As a result the person looked uncomfortable at times. We observed that due to one person's behaviour another person did not eat their main meal but only their pudding. Staff did not take appropriate action to make sure the person was comfortable and able to eat their full meal.

Failing to ensure that people had support to eat in line with their choices and needs was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with food and drink which supported them to maintain a healthy diet. Kitchen staff had information relating to people's individual dietary. They told us they were new to the service so had started to write a list of people likes and dislikes so they could adapt the menu to suit people. The meals served looked appetising and portion sizes were good. One person told us the food was good and a relative said, "She has a good appetite and enjoys her food." Records were kept of people's nutritional intake and any supplements provided. People's weight was monitored regularly and action taken when significant changes were noted.

The provider had considered people's needs when people were living with dementia by adapting the premises to help them remain independent. For example, hand-rails were painted in a bright colour and

toilet doors were painted in a contrasting colour to ensure they stood out to people. The communal areas of the home were open plan making it easy for people to access all areas of the home.

People were supported to stay healthy. This included calling the doctor as required and having access to chiropody, community psychiatric nurses and district nurses. The registered manager demonstrated a good understanding of people's health care needs. Relatives told us that they were kept informed if their family member was unwell. People were weighed regularly and there was evidence to show that any significant changes were reported to the persons GP.

Inadequate

# Is the service caring?

## Our findings

People and relatives told us they felt the service was caring. One person said, "It's lovely here. The staff are nice." Another person said, "It's beautiful, I would say if I was unhappy." This was reiterated by their relative. Another person said, "I like it here. It's lovely." A relative told us their family member was very happy, "She's always smiling and smiling when I leave." They added they felt their family member was, "Well cared for and happy." Despite these comments we found the service was not always caring.

People were not always cared for in a respectful manner. When we arrived on the first day of the inspection we observed that the majority of people were sat in the dining room or lounge area at 0900 and were finishing breakfast. We were concerned that people may be being woken up at an unreasonable time so arrived for the second day of our inspection at 0700. We found that 13 people were seated in the lounge or dining area having already been supported with personal care. At this time five people were asleep in their chairs. One person told us, "It makes it a very long day." They told us staff, "rap" on the door and tell them it's time to get up. They added they would like to stay in bed longer if they could. We observed another person falling asleep at the dining room table. They also told us they would like to stay in bed longer. During the inspection we observed that people frequently spent time asleep in their chairs.

Staff told us they started supporting people with personal care at 0445 One staff member told us they were expected to get 12 people up before the day staff arrived at 0800 however another staff member said they only got people up because they were awake. On the first day of our inspection the registered manager told us that night staff started to get people up at 6am due to their continence needs. They said, "There is not a certain number (of people) or specific people." On the second day of our inspection the registered manager told us they were shocked and upset that night staff were getting people up so early. She said that she had suspicions that this might be happening so had told staff they did not need to make sure people were up and ready for when the day staff arrived. The staff had not followed this direct instruction from the registered manager and had continued to get people up before they would wish to.

People's dignity was not always respected. People with continence needs were not supported appropriately. Team meeting minutes stated, 'Incontinence pads are only to be used for people that require them. They are not to be used at night.' The registered manager told us that they did not believe it was healthy for people to wear continence aids at night as well as during the day and had always told staff they should not use them. They said that people were provided with washable padded bed sheets so they would not be uncomfortable due to incontinence. The registered manager confirmed that people were not given a choice regarding their continence care at night.

Staff told us that the padded bed sheets were not used very often and we saw on the second day of our inspection that they had not been used as there were none in the laundry room despite there being soiled night clothes. This meant that when people experienced incontinence in the night they had no protection and were left in a wet or soiled bed until staff supported them. We saw that 11 people's beds had been stripped and one staff member told us this was because people had been incontinent. They told us, "If they are wet in the night we change the sheets and their clothes. We sometimes change people's beds twice in

the night."

We discussed our concerns with the registered manager who told us they would inform staff that people should be supported to wear continence aids during the night.

We saw one member of staff brush peoples hair in the lounge by using the same hairbrush. Some people were asleep but had their hair brushed despite this. One person who had very poor eyesight however we saw that on the second day that their glasses were dirty.

Staff did not always speak to people in a respectful way. We observed one staff member supporting someone to the toilet. The person was being hurried and the staff member said, "Hurry up, come on let's go." On another occasion we heard a different staff member in the lounge say in a loud voice, "(Name) you are wet, we've got to change your trousers." When the person refused and said they were fine, the staff member said, "Oh my God, no you are not."

Not ensuring people were treated in a dignified and respectful manner was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During both days of the inspection we also saw some positive interactions between people and staff. We observed one person become confused about where their room was. The staff member spent time reassuring the person and explaining where their room was. On another occasions we saw staff support people with their personal care in a discreet manner. When one person said they were cold a staff member supported them to put a cardigan on. Their approach was gentle and reassuring.

People's privacy was respected, except in the instances where staff did not help people discreetly. Staff were seen to knock on people's doors before entering and doors were closed when people were being supported with personal care. One staff member told us they would not speak about people in front of others. There was a small lounge people could sit if they wanted some privacy.

Requires Improvement

# Is the service responsive?

## Our findings

People and their relatives were not involved in developing their care plans. One relative told us they had never seen their family members care plan, "She probably has one, but I don't know." Another relative said they knew there was a care plan but added they had, "Not been involved in reviews for quite a while."

Assessments of people's needs were completed prior to them moving into the service. However, assessments were completed on tick box style forms and did not contain comprehensive details regarding people's needs, medical histories and personal preferences. Because of this the provider could not assure themselves, or people that their needs could fully be met by moving to this home.

One person's assessment stated, 'Prone to stress and anxiety' and, 'episodes of aggressive behaviour'. The assessment did not contain details of how the person's anxiety affected them. The person had lived at the home for 11 months but did not have a care plan in place and there was no guidance available for staff as to how to support the person with their anxiety. We observed the person become extremely anxious and verbally abusive to people on numerous occasions during our inspection. We saw this led to them being slapped on the hand by another person on one occasion and threatened on another occasion. Staff did not respond to the person in a consistent manner, sometimes ignoring them, sometimes telling them to stop and sometimes offering reassurance. The lack of planned interventions to support the person meant that they did not receive the support they required to manage their anxiety and created distress for others.

Care plans were not person centred. The care plans we viewed did not contain information regarding people's individual likes, dislikes and personal preferences. There was no information available to staff about people's life histories or interests to enable staff to offer personalised support. One staff member told us they would like more personal information in care plans regarding the people's lives and medical conditions. They said this would allow them to provide more individualised care.

People did not have access to activities which reflected their individual needs and preferences. Two relatives told us they would like to see more for their family members to do. One person said, "There isn't much going on here." We observed people spent most of their day watching television or sleeping in their chairs. When a staff member spent time playing board games with people they responded positively to this, appearing alert and smiling in response to the staff members interaction.

The registered manager told us that there was no designated activity worker in place and staff were responsible for completing activities with people on a day to day basis. A pet therapy dog visited the service each week and an external activity worker visited for one hour each week. The activity board in the hall displayed activities including musical afternoon, pet dog visit, bingo and card games. On the first day of the inspection 'nail care' was listed as the activity although this did not take place. Activity records were repetitive and listed nail care, bingo, card games and ball games. There was no evidence available to show how the service supported people to maintain previous hobbies and interest or to develop new ones.

Not completing comprehensive assessments of people's needs and care plans not being completed in a

personalised manner, along with a lack of activities which suited people's individual needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place and was included within the resident's handbook. The procedure told people how to complain and who to complain to. A complaints log was in place which showed the last complaint to the service had been received in 2010. The registered manager confirmed that this was the case. They told us that they were in regular contact with families and would address any concerns immediately so the formal complaints process was rarely required. Relatives told us that the registered manager was approachable and should they have any concerns they would be addressed by the manager.

Inadequate

# Is the service well-led?

## Our findings

Relatives told us they felt the home was well-led. One relative said the manager was accessible and always made time for them. They added, "Staff are very nice and the manager is very helpful, she was the reason why we chose to place. We are very, very happy at the moment". Another relative said of the registered manager, "Brilliant. She doesn't stop." They added that they also saw the owners regularly who had always been, "really nice."

Despite these comments we found the home was not well-led as a number of issues were identified which showed improvements were needed. We spoke to the registered manager about our concerns regarding the unreasonable time people were woken up in the morning. They told us they had previously had suspicions this was happening. However, they had not taken any action to investigate this, such as completing night checks. The registered manager said they were not aware that staff were using drag lifts to support people with their moving and handling needs although they had been present on a number of occasions when we had observed this practice.

Quality assurance audits were not completed and there was a lack of managerial oversight of the service. There was no evidence that regular audits were undertaken to assess, monitor or improve the quality and effectiveness of the service. Internal audits of medicines, infection control, care planning or health and safety had not been completed and systems were not in place. Records of people's care were not reviewed against daily records to monitor if people had received the quality care they required.

The registered manager did not receive effective support from the provider. The registered manager told us that the provider was based in the building and regularly visited people. They said they felt supported by the provider and that requests for resources were acted upon. However, the provider had not supported the registered manager to recognise the improvements required within the service and had not ensured that quality assurance systems were in place.

The registered manager had not always notified the Care Quality Commission appropriately of a number of incidents which had occurred in the service. We had not been notified of an event which may have stopped the service running safely or of the outcome of a DoLS application. The registered manager told us they were not aware this should have been done. We had received appropriate notifications relating to a number of other incidents.

Records not being completed accurately which meant people were at risk of not receiving the care they required. We viewed records of people's care at night which included the care they had received when getting ready for the day. These had been completed prior to people receiving care and were still being supported to get up. Two people's records stated they had been supported to have a shower. However shower rooms had not been used that day. This meant that staff had completed records inaccurately.

People's care records were not organised and not effective in providing quick access to information for staff. When care plans had been reviewed information was not updated to reflect changes in people's needs. For

example, we viewed one person's care plan which was completed in 2013. Review notes showed the persons care needs had changed significantly during this time but the care plan had not been updated. The care plan stated the person, 'mobiles independently without aids, very sure-footed'. A more recent review of the person's care stated, 'two staff for all transfers, full hoist'. There was no information for staff as to the type or size of sling which should be used. This meant that guidance to staff on how to support the person was not up to date and the person was at risk of receiving care that was not safe for them.

Accidents and incidents were not monitored and reviewed to ensure that they did not reoccur. There were systems in place for monitoring accidents and incidents and we saw a number of entries had been made. However, there was no evidence that action had been taken to minimise risk and care plans had not been changed. We observed a number of incidents during the day where people had become abusive towards others and caused distress. These incidents had not been appropriately recorded. A number of people had behavioural recording charts in place although these were not completed in detail and some comments were derogatory towards people. For example, one person records stated, ''X was his usual demanding self." There was no evidence to show how information from behavioural recording was used to minimise risks to people or guidance to staff as to how to support them to minimise anxiety.

The lack of effective quality assurance systems and the failure to maintain accurate and up to date records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback on the quality of the service from family members was sought. A survey of relatives had been completed in 2015. The results were displayed clearly in the communal hall and were largely positive. However, there was no action plan in place to address how comments and concerns were to be addressed.

Staff told us they felt supported by the registered manager. One staff member they had learnt a lot from her and described her as, "Number one." There was evidence that regular staff meetings were held and staff told us they felt comfortable in raising issues. Another staff member said they felt that staff worked as a team. During the inspection we saw the registered manager spent time with people and staff and there was an open and friendly atmosphere.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The registered provider had not ensured people were receiving safe and appropriate care and support because they did not have a detailed assessment of needs or personalised care plan.<br><br>The registered provider had failed to provide activities which reflected people's individual needs and preferences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had not ensured that people's legal rights were protected as the requirements of the Mental Capacity Act 2005 were not being met. |

| 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<br><br>The registered provider had failed to ensure systems and processes were in place to protect people from potential abuse. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The registered provider had not ensured people |

had the support they required to eat in line with their needs.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered provider had failed to ensure staff received the support they required in their roles. |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The registered provider had not ensured people were treated with dignity and respect. |

**The enforcement action we took:**

Warning notice in progress

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered provider had not ensured care was provided in a safe way.<br><br>The registered provider had not ensured care plans were in place to guide staff in providing safe care.<br><br>The registered provider had not ensured that staff received mandatory training.<br><br>The registered provider had not ensured safe management of medicines procedures.<br><br>The registered provider had not implemented safe infection control procedures. |

**The enforcement action we took:**

Warning Notice in progress

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider had not ensured systems were in place to assess, monitor and improve the quality of the service provided.<br><br>The registered provider had failed to ensure |

accurate and transparent recording.

**The enforcement action we took:**

Warning Notice in progress