Caring in Care Limited

Caring in Care Limited - Holly Cottage

Inspection report

Holly Cottage
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28 September 2016

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

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 28 September 2016 and was unannounced. The inspection was carried out by one inspector.

The provider completed a Provider Information Return (PIR) before the inspection. This 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. We used this information to help us plan the focus of our inspection.

Before we carried out this inspection, we also reviewed the information we held about this service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about. We also made contact with the local authority quality assurance team to ask their views on the quality of the service.

During our inspection we spoke with one person who used the service. Some other people who used the service were unable to tell us verbally about their experience of care. We made observations of people's experience of care and how staff interacted with people. This enabled us to better understand people's experience of the support they received. We also spoke with two peoples' relatives,

We spoke with two care staff, the manager and one of the directors. During the inspection we looked at two people's support plans as well as records in relation to the management of the service including staff recruitment records, staff supervisions, complaints procedures and quality assurance records.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were stored safely but not managed effectively which placed people at risk of harm.

There were enough staff to provide people with support when it was required during the day but not overnight.

Appropriate recruitment checks had been undertaken prior to staff commencing employment.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act 2005 were not always followed.

There was use of monitoring equipment, primarily to promote the safety of people with epilepsy, but which intruded upon the privacy of
people using the service.

People had access to healthcare professionals to ensure they received effective care and support.

Staff received some training to help them carry out their job role.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

People were not always involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service was not person centred. Rules were in place and people had not been consulted about them.

The service was institutionalised and restrictive practice was used.

A complaints procedure was in place however it was inaccurate and not always accessible to people who used the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service lacked appropriate governance to ensure that people were supported in a person centred way.

The quality monitoring arrangements were not fully effective. They had not identified the concerns and breaches of regulations that were identified at this inspection.

Caring in Care Limited - Holly Cottage

Detailed findings

Background to this inspection

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people's support plans as well as records in relation to the management of the service including staff recruitment records, staff supervisions, complaints procedures and quality assurance records.

Requires Improvement

Our findings

A pharmacy supplied medicines to people living at Holly Cottage in a monitored dosage system. A monitored dosage system is where tablets are stored in separate compartments for administration at a set time of day. The pharmacy also supplied printed Medication Administration Records (MARs) for staff to record medicine they had given to people who used the service. We checked completed MARs and found gaps on several records where staff had not recorded whether that person had been given their medicine as prescribed. The manager told us that they had not identified the gaps that we did in the MARs at the time of our visit. They told us that if they identified gaps in staff recording, care staff would be reminded of the correct procedure and re-trained in medicines if necessary.

MAR charts did not always contain up to date information on the quantity of medicines stored within the service, when they had been received by the service or by whom. During our audit of medicines we compared medication records against quantities of medicines available for administration. In all instances on the MAR charts in use, we found amounts of medicines carried forward from one month to the following were not recorded so it was not possible for the manager to audit them fully. The manager told us that they had been on leave and in their absence the correct process had not been followed and that ordinarily medicines stock levels were carried forward from one month to the next.

One person had their medicines crushed and placed in food in order for them to take it. We found there was no record of contact with or an agreement by pharmacist to ensure that it was safe to crush the medicines. The person had not been consulted.

We checked the storage of medicines that were to be returned to the supplying pharmacy. We saw that there were a number of medicines in tablet form that were stored in clear plastic bags. Whilst these had the initials of the person whose medicines they were on them, there was no description of what the medicines were or why they were in the bag and being returned. The manager told us that staff had been using the incorrect labels and process for returning the medicines.

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

One person who we spoke with told us, "Staff are good to me. No one has shouted at me, they look after me."

We observed that there were sufficient staff members on duty during the day to enable people's needs to be met. The service supported people with a range of different support needs and dependency levels. The manager told us that there were usually three staff on during the day, sometimes four. There was one waking night staff who worked overnight. During our visit there were four staff on duty. Two staff members were based at the service, and two had gone out with people. Staff told us that one of the staff on duty on the day of our visit had been requested to come in due to there being an inspection and to enable the manager time to spend with the inspector.. We noted that there was always a staff presence in communal areas of the home. However, there were not enough staff overnight. The staffing levels that the manager confirmed to us were in place at night showed there were insufficient staff to support people to get out of bed if they requested to get up and required assistance with a hoist to do so. We were told by the manager after our visit that there was an on call system in place and the member of staff on call could get to Holly Cottage within 10 minutes to support with any emergency situation. The manager told us that, overnight, if a person needed assistance with a hoist, one member of staff could do this if it was a 'life and death situation'.

People had emergency evacuation plans in place in the event of a situation where they needed to evacuate the service quickly. One person's plan stated that if the person could not be helped out of bed with the hoist, staff could use a duvet to help them slide off their bed and to the fire exit. The evacuation plan also stated that if this were the case support should be sought from two other staff to safely transfer the individual. We found that due to the level of staff available overnight at the service, it would not be possible for the manager and staff to work to their own emergency plans.
We concluded that this meant that people who may have requested staff assistance with a hoist to get up overnight could not do so routinely due to the level of staffing. This meant that their needs could not be met in an individualised and responsive way. We also concluded that the staffing levels were not sufficient overnight in order that people's personal evacuation plans could be followed in the event of an emergency.

This was a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had attended training on safeguarding adults from abuse. They were able to describe different types of abuse that they might observe and told us that they would not hesitate to report their concerns to the manager or one of the senior staff. They were confident that the information would be dealt with so that people were protected from the risk of harm. One member of staff we spoke with said, "Any issues and I would be straight to the manager and telling them my concerns."

We checked the recruitment records for two members of staff. We saw that staff applying for a job were required to complete an application form setting out their previous experience and relevant skills. Staff were only recruited after an interview to assess their suitability for the role, receipt of satisfactory references and Disclosure and Barring Service (DBS) checks had been carried out. The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. Documents such as photographic identification from staff members had been retained. There was a record of the questions asked and responses received at the employment interview.

A range of environmental risk assessments were in place to minimise the risk to people and staff. Each person's care plan contained individual risk assessments in which risks to their safety were identified. Hazards had been identified together with who might be harmed, what the service was doing to minimise the risk and any further action required. We saw however that risk assessments were not carried out effectively as any potential hazards still remaining were not assessed.

We saw an example of a risk that had not been effectively identified by the manager. One person was prescribed a drink additive for fluid thickening. This had been left on a shelf in the lounge during the day unattended. This was a concern because the drink thickener posed a choking risk to people if consumed without the correct guidance being followed. We spoke to the manager about this and they told us that the thickener was usually kept securely.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the electrical installation, gas safety, mobility equipment, portable electrical appliances, the fire alarm system, emergency lighting and fire extinguishers. In-house checks were carried out on the fire alarms and emergency lighting. These measures helped to make sure that the premises remained safe for the people who lived and worked at the service.

Requires Improvement

Our findings

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.

We looked at how the MCA was being implemented and checked whether the service was working within the principles of the MCA. We also reviewed whether any conditions on authorisations to deprive a person of their liberty were being met. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

During a review of people's care records we found inconsistency in the application of the MCA in relation to restrictive practice. Consent had not always been recorded to show that people had agreed to having restrictions in place. For example, within care records we found one person who we were told lacked capacity to make their own decisions, had an assessment completed for the decision to have bed rails. The assessment stated that the person could not sign and had verbally agreed. The document had been signed by staff. There was no information within the care plan about who had been involved in determining this was in their best interests.

We also found that where a person had their medicines covertly (placed in their food without their knowledge as they did not have mental capacity to consent to it) administered by staff there was no supporting best interest decision process or paperwork. When medicines are administered in this manner, there is a requirement that the service demonstrate why the decision had been taken to administer the medicines in this way and why it was in the person's best interest. This would ensure that consideration had been given to ensure a person's human rights have been upheld in accordance with the Mental Capacity Act 2005.

Staff had limited knowledge of the MCA however they knew that it related to people's ability to understand and make their own choices. We asked staff about how they sought people's consent. Staff were aware that some people needed support to make decisions and they told us that they would offer choice where they could. One member of staff described how one person could make a choice using picture cards. We did not observe these in use with the person during the day of our inspection. The member of staff told us that they

were not 100% sure of the criteria of when the picture cards should be used.

One person's support plan had a document in it relating to an advanced care plan and a document setting out whether the person wished to be resuscitated or treated should they become very unwell. These documents stated that the persons 'lasting power of attorney' (LPA) had been consulted. A LPA is a legal tool that gives another adult the legal authority to make certain decisions for a person, if they become unable to make them for themselves. However when we asked the manager and one of the directors whether the LPA was in place for the person, they checked and established that it was not.

We could not be assured that staff fully understood how to assess people's capacity and follow legal processes to ensure they were acting in people's best interests.

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

The registered provider required staff to complete a range of training to equip them with the skills needed to carry out their roles effectively. Training was provided through the use of a range of DVDs which staff watched. We asked the manager for details of the dates that all staff last undertook the training which the provider deemed necessary. When we received the training information we noted that staff undertook training in key areas of care and support such as safeguarding, dignity, epilepsy, MCA, equality and diversity all on the same day by watching DVDs. All training undertaken however was in date and had been renewed appropriately.

Specific individual training in person centred care was not included as part of the training that staff undertook however staff did cover this issue within the Care Certificate training they undertook. This meant that some staff, despite having training and knowledge in person centred care, did not recognise that practices at the service were not person centred. Person centred care is an approach that that takes into account people's needs, preferences and strengths.

Staff told us that they received regular supervisions and felt supported by the management team. One staff member said, "I have supervision every three months. I think it is enough. In between there is an 'open door' policy and I can sit and talk if needed."

One person told us that they liked the food at Holly Cottage and told us, "I like everything on the menu." Another person's relative told us, "They've [staff] told us that they will get the food in that our [relative] likes for them."

Some people had restrictions on their diets by the manager and staff such as a limited number of biscuits which they were permitted to consume. Other people had care plans in place where it was recorded that they were to have fruit or yoghurt instead of puddings and no full fat food on a regular basis. This plan of care was in place without any consultation with people themselves or from a dietician and had been implemented by the manager.

We observed lunch time and saw that one person ate independently whilst another required staff assistance with their meal. Neither person was asked what they wanted for lunch. Both were presented with their food on a plate ready prepared. Whilst one member of staff was supporting a person to eat and drink, we saw that there were lots of missed opportunities for them to engage with that person. They did not explain what was in their blended meal or communicate with them about their preferences or whether they liked their meal. After our visit one of the directors told us that people were asked what they would like for lunch that

day in the mornings.

People who required a modified diet to ensure the texture of their food was suitable were appropriately supported. We saw that guidance written by the speech and language therapist was followed by staff and that the food offered to the person was in line with the care plan. All of the staff we spoke with knew people's dietary requirements.

Care records showed people had access to healthcare. People were registered with a GP and records showed that they attended appointments. Where people had additional healthcare support their advice was recorded within care records to help staff provide appropriate care. People were weighed regularly to monitor any changes and participated in regular health checks by their GP.

Requires Improvement

Our findings

We saw that listening devices (baby monitors) were used to monitor some people whilst in their bedrooms. We were told that these were for the use of monitoring people for safety reasons during the night time and when they were in their rooms alone. Transmitters were in people's private rooms and broadcast the sound of what was going on into one of the communal lounges. During our inspection some people were in their rooms and the monitors were a live feed from those people's bedrooms to the lounge. The lounge was an open and accessible space to other people living in the service and visitors. Staff told us that these were in use so that people could be monitored for safety reasons, including in case of epilepsy and for people to call out for help or reassurance.

In some cases, the use of the monitors had been discussed with and agreed by the person who used them. There was, however, no plan for when the monitors should be used and when they should be switched off for privacy reasons. For people without capacity to consent to the use of the monitors we found that these had not been subject to proper consideration in line with current published guidance about the use of surveillance. There was also no consideration as to whether other, less intrusive arrangements could be accessed to enable staff to monitor people. People had not been consulted in order to determine whether they were able to give explicit consent to the use of the system to promote their safety.

During our observations we saw that not all staff took a caring approach and we noted some were not encouraging when they delivered support and did not treat people with dignity and respect. We observed a staff member moved one person in their wheelchair with no prior communication. On numerous occasions we saw that staff walked up behind a person's wheelchair and move them. This was either to support them to have a meal or to move them out of the way for other people and staff to get past them. They did this without talking to the person first or warning them that they were about to be moved.

On our arrival and whilst we were being shown around the service we saw that one person needed assistance with cleaning around their mouth. Around 30 minutes later we observed a member of staff pick up a wet wipe, walk over to the person who required assistance and wipe their face. At no point during this interaction did the staff member communicate with the person or ask them if it was okay for them to do so. We spoke to the manager about our concerns and observations as part of our feedback on our visit. They told us they thought this was not usual practice at the service and would be addressed with staff.

Within each person's room they had an en suite toilet. Displayed on the outside of the door to the en suite, each person had an A4 piece of paper which included personal information about their continence and the

type of support they required. Because most people kept their bedroom doors open during the day these notices were visible to people within the service. They were therefore also clearly displayed if people were to have friends, relatives or other visitors. This was not respectful to people's privacy or dignity. We spoke to the manager about our concerns about the notices and their impact on people privacy and dignity. They agreed to take immediate action to remove them from view.

Whilst people were supported to maintain relationships with people that were important to them we were told by one person's relative that they were able to visit their family member however they could not do so in the mornings or after 4.30pm. They told us that after 4.30pm staff are preparing the evening meal so they were not to visit. We concluded that the rules and restrictions around people and visitors were restrictive and did not demonstrate respect for their dignity or individuality. Following our visit one of the directors told us that they have no restrictions on visiting and have since made all people's relatives aware of this.

The lack of dignity and respect for people was a breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We did observe one staff member who was particularly kind and caring to people. They took the time to ask people about their particular needs and what they wanted to do and if they needed assistance with anything. They talked to people in an appropriate way and were interested in what they had to say.

People received their personal care support in private. We observed staff closing people's bedroom doors before they helped them. One member of staff said, "We always have at least one female member of staff on duty for those people who prefer that. When I am helping anyone with personal care I always make sure their door and curtains are closed so no one can walk past and see. Other staff knock before they come in so the staff member helping someone has a chance to cover them up."

We saw that people had been supported to personalise their bedrooms with photographs, pictures and other items that made it individual. We spoke with one member of staff who had worked at the home for a number of years. They had a good knowledge of people's individual needs and their personalities.

The manager told us that no one currently needed to access an advocacy service; however they knew how to access one that could be used if needed. Advocates are people who are independent of a service and support people to make decisions and communicate their wishes and views.

Requires Improvement

Our findings

We found that the service people received was regimented and did not consider their individual personalities, needs and wishes. We spoke with one person who was able to talk to us about their experiences of living at Holly Cottage. They said that they were happy living at the service and that the staff were 'good to them'. However, they also told us, "My lights have to be off and 10.30pm and my TV off at 11pm. I want to watch [particular program] on TV but I can't as it is on too late. I am trying to get a box [satellite] that will record so I can watch it." We asked the person why their lights and TV had to be off at a certain time. They told us, "It is management rules. They [management] don't like the TV left on." We asked the manager about why these restrictions were placed on this person and why they didn't have the choice to watch their television later when they wanted to. The manager told us that the person needed encouragement to go to sleep at night as it was important that all people get a good night's sleep. The manager's view did not take into consideration that some people by choice prefer to stay up late at night regularly or on occasions.

The ethos of the service was one of rules and restrictions. Staff gave people care and support but person centred planning was not used to help people develop. Independence building was not in the forefront of care planning and we found very little evidence to show that this was discussed with people. Displayed in the hallway of the service was a list of 15 rules that were entitled 'House Rules'. We were concerned about the restrictive nature of the rules and the fact that they were 'blanket' rules for everyone, not person centred and did not promote choice and independence. There was also no evidence to demonstrate how people had been consulted about the rules they had to live with.

We spoke with the manager about the rules and requested to know how they had been developed and whether this had been in consultation with the people who lived at the service. We also requested to know how people had been supported to understand the house rules and how they had been made accessible to people who may not have had the mental capacity to understand them. The manager was unable to produce evidence of how this took place.

The manager told us that there were two versions of the house rules, one for the summer and one for the winter. They told us that the difference between the two sets of rules was that people were not permitted to have the doors and windows open in the winter. They also told us that most of the rules had been in place for a long time. They said, "People don't necessarily have to abide by them but we do encourage them." We noted that some of the house rules were about restrictions imposed on people such as the communal televisions needing to be switched off between 11pm and 7am each night.

There were further restrictions on some people whereby if they required help with a hoist or two members of care staff to help them up, they were not able to do so overnight. This was due to the staffing level at the service over night. The manager told us that this was because there were insufficient staff to help people up and out of bed during the night if they wanted to get up. This meant that people's support needs were not being met in a personalised way.

Another house rule stated that people were not allowed to eat or keep any food in their bedrooms unless supervised by staff. This practice and blanket restriction on people not being allowed to eat in their rooms did not promote individuality and independence and was not based on an assessment of people's capacity to make this decision for themselves. When we asked the manager about this rule they told it was to prevent infestations of rodents at the service.

There was a rule about the times that meals should be served. The manager told us that there were set hours for mealtimes as per rules however people did have meals at other times too. We looked at copy of the house menus and saw that portion sizes were prescriptive on the menus such as an allowance of a maximum of 8oz of cereal for breakfast, maximum 2 slices of toast for breakfast and a maximum of two biscuits per day. We spoke with the manager about these further restrictive approaches. They told us that they had previously had an issue with staff not serving food appropriately with some people having too much or too little. They told us that they had introduced this rule on quantities as, "It makes everyone [people] have the same amount and in a more presentable manner." People did not have an assessment by and input from a dietician in order for appropriate restrictions on their nutrition to be put in place.
We spoke with one person's relative who told us that fruit or any other food such as chocolate that they took to Holly Cottage for their family member had to be handed to staff who then kept it in a locked 'tuck box'. They told us, "They [people who live at Holly Cottage] all have to have tuck boxes. If we take any food in, we have to give it to staff on duty. They then lock it up in their tuck boxes. We know that this is one of the rules. They [staff] then let them have a little each day." Although a family member told us that they thought this was a positive action by the service we found that people had not been consulted on the use of the tuck boxes. We also found that where people did not have the capacity to decide for themselves, no best interest's decision had been made to hold onto people's food. We asked the manager how the system worked. They told us that the 'tuck boxes' were kept in the services kitchen and, "Controlled under food hygiene and would be served as requested."

Food in fridges and freezers as well as some dry food was kept in a locked room which the manager told us, only staff had access to. Within this area there was a further locked room where the main supplied of dry foods were kept. We asked staff about how people made choices and how they could access food when they wanted to. One member of staff we spoke with told us, "It's no unauthorised access. Staff can go in. It's only [people who live at the service] who are not allowed to access the food. This is to protect them from themselves and any binging." We found that there was nothing within peoples care plans to state that restricting their access to the kitchen was in their best interests or necessary to safeguard them from a medical condition.

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

We asked one person if they received the care they wanted to have. They told us, "It's alright. They [staff] take us out; I go shopping when it is my turn. I go bowling and to the gym. All staff are nice and polite to me."

People living at Holly Cottage each had their own support plan. We looked at four people's support plans and found that they were not all up to date. Some information had been crossed out and additional notes

made on the document by staff. The care plan however, had not been updated. For example one person had a care plan in place about the use of paracetamol. The care plan was written during December 2011 and was last reviewed in February 2015 where the use of paracetamol was discontinued. however the care plan had not been removed from the persons file. When there have been changes to a person's care needs if the original care plan is not amended there is a risk that staff don't have the most up to date information in order to meet the persons needs. We also saw one person had an up to date support plan which had been completed and reviewed more recently.

Support plans would benefit from focussing in the future on what people are able to do for themselves and how they can be supported to make their own choices . One person's support plan however did include information about their preference for gender specific care. Staff we spoke with told us that there is always a specific gender of staff on duty to meet such preferences.

Each person had an activity plan. The manager told us that people were expected to follow the summer or winter activity plan, however there could be some variation if a person wanted to do something different. We saw that discussion had taken place during people's house meetings about activities and individuals had made suggestions for the activities they would like to take part in. On our arrival we saw that two people were leaving the service to go bowling with staff support. During our inspection we saw that one person went out into the village for a walk with a member of staff. We saw another person chose to sit in the lounge and another to watch a DVD. Other people were out at their day centre they attended. We found evidence of some information in people's support plans about their interests and activities that appeared to be taking place. However we were concerned about the lack of choice implied by the activity plan which stated for example when some people were swimming all others would be playing board games. Another example was when some people were at the gym all other people would be taking part in arts and crafts.

Each person had a key worker. A key worker is a staff member who focused on an individual and made sure that their care needs were met and reviewed. One person told us about their key worker saying, "My key worker is [staff member]. They are good to me, they look after me. They [key worker] haven't ever talked to me about my support plan. I don't know about that." After our visit one of the directors told us that support plans were referred to as care plans at the service so therefore the person may not have fully understood our question. We asked staff about the role of a key worker at Holly Cottage. One member of staff said, "Everyone [people] has a key worker. The key workers review the care plans and update them and they discuss the changes with the manager. People who can be involved, then we will sit with them and discuss what is happening."

We looked at how the provider managed complaints. There was 'concerns and complaints procedure' in place for dealing with complaints however this had not been reviewed and updated since 2009. This document was not accessible to all people living in the service as it was in written text. There was no alternative version on display that had been made accessible to people who could not read the text one, There was no evidence that people were spoken to about how they could make a complaint. After our visit one of the directors sent us a copy of an easy read complaints guide which they told us was contained within the service user's guide. We found that the easy read version did not include any contact details for any organisation that a person could get in touch with to make a complaint.

Requires Improvement

Our findings

Despite staff and relatives speaking positively about the manager, we found that aspects of the service were not always well led. Although there were systems in place to assess and monitor the way the service was run, we found that they had not identified all of the concerns that we found during our visit.

There were a number of restrictive practices placed on people without justifiable reason and without their consent, or a best interest's process being followed. The manager told us that the rules and practices were in place, some of them for a number of years. The culture of the service was institutionalised. People had their basic care needs met but the service was not treating people as individuals. The manager and directors had failed to recognise that people were not receiving person centred care.

We had concerns that some systems for monitoring and checking the quality and safety of the service were not always effective in identifying where improvements needed to be made. This included concerns about the use of electronic monitoring without reference to appropriate published guidance.

We saw that audits of the medicines had taken place, however this was not effective because it did not pick up a number of gaps in staff signing for medicines administration that we identified at inspection. The audits completed were not detailed and did not include actions that were taken if a concern was found. A pharmacist advice visit had been carried out by the supplying pharmacy during August 2015. This audit of the medicines had also identified that records of administration did not evidence medicines carried forward from one month to another. During our inspection we found the same concern. We could not be assured that people were receiving their medicines safely.

Satisfaction surveys were distributed to people who lived at the service. These were in written text format and we saw that there had not been an attempt to devise these in a pictorial or accessible format. Staff had told us about at least one person who could use picture cards to communicate some preferences. Surveys however had not been produced in this format to assist people who could not read written text.

In one survey people were asked if they liked living at Holly Cottage. They were also asked if there were areas that the service could improve and if there were areas that people did not like. There had been four surveys returned for 2016. These had been signed and dated and in some cases had been completed by care staff. Following our visit one of the directors of the company told us that care staff recorded verbal answers that people gave. The responses we saw included, 'I like everything' as well as 'I would like an Indian curry'. In response to the question about whether people liked living at Holly Cottage, we saw comments such as 'Yes

I do!' and 'Yes.' During the surveys completed for 2015 we noted that one person had raised that they would like the service to 'not be so strict when not needed.' Another person had raised that they would, 'would like TV to stay on later.' We noted that during the 2015 survey that people were also positive about living at Holly Cottage. An action plan was raised following the surveys in both 2015 and 2016 to analyse the points made and actions to be taken.

The lack of appropriate leadership was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with described team work as good. They told us that they felt their colleagues were supportive. Staff attended regular staff meetings where their views were encouraged. These meetings were also used to share important information and updates about the service. Staff told us that the meetings were a chance for them to share views and opinions and that they could speak openly.

We spoke to one person's relative. They were positive about the management of the service and how it was run and said the all the staff were "fantastic." They said they felt they were given information when they asked for it.

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 The registered provider had put in place rules and restrictions that people were expected to live with and comply with despite not being consulted during the development of the rules.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy was not maintained at all times and monitoring measures had not been properly considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act were not being followed as assessments on capacity to make decisions were not completed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Care and treatment was not always provided in a safe way. The management of medicines was not always safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager and provider failed to put in place effective systems for auditing the quality of the service. Management and oversight of the service were not effective in evaluating and improving person centred practice and preventing restrictive practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager and provider failed to adequately deploy staff to meet people's needs during the night in a responsive manner.