

Hewitt-Hill Limited

Fairland House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We carried out an unannounced inspection over two days on the 16 and 20 December 2016. On the second day we had arranged to go back to meet with the owner of the care service and to look at further records. At the last inspection to the service on the 05 December 2013 the service was found to be meeting all the required standards.

The service provides accommodation and care for up to 34 older people. At the time of our inspection there was no registered manager in post. The owner had appointed a manager and they had been in post approximately three weeks and were supported by a deputy manager, senior staff and a full complement of staff. They told us they intended to apply for registration with the Care Quality Commission.

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.

In summary we found that people were well cared for by staff that were familiar with their needs and responsive to their wishes. People gave us positive feedback about their experiences and the staff that cared for them. The environment was clean and well maintained and refurbishment was on-going. A lift had been installed in the last few weeks. Prior to this a stair lift was in situ.

The manager was newly in post and already identified what they needed to put in place to ensure the smooth running of the service. Staffing levels were being maintained but occasional agency staff were being used to cover long term sickness. Staff were also being deployed to cover gaps in the rotas which effectively reduced the amount of care hours being provided. For example care staff were doing laundry and activity staff doing care hours. This impacted on people's experiences.

We have made a recommendation about the use of a dependency tool to establish people's needs which will help determine how many staff are required.

Staff were aware of people's needs but people's records did not clearly reflect their needs or provide information about how risks were to be effectively managed and monitored. It was evident that because staff knew people they were quick to refer concerns to other health care professionals but in terms of accountability. There were not clear records of the care given in accordance with people's needs.

We have made a recommendation about information required in an emergency. Do not attempt pulmonary resuscitation. DNAPR.

Staff promoted people's well-being and offered them meaningful choice. However we were not assured that the service always assessed capacity in line with the Act or always acted in a person's best interest as there

was very little recorded in people's records about capacity, risk taking and promoting choice. The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. Where people's liberty needs to be restricted for their own safety, this must be done in accordance with legal requirements. People's capacity to give consent had been assessed and decisions had been taken in line with their best interests. DoLS applications had been appropriately submitted to the local authority. We have identified a breach.

Servicing and auditing of equipment and premises were in place to ensure safe systems of work but these were not sufficiently robust. We found records of accidents, incidents, falls and occurrences in place but no clear overview of these to help determine patterns and trends over time.

There were systems in place to ensure people received their medicines as prescribed and staff were trained to administer them. Minor concerns were identified, which we will comment further upon in the main body of the report and were being addressed by the staff.

We have made a recommendation about keeping records together in terms of people's medicines and risks associated with administration.

Staff recruitment processes were adequate but staff records had not been clearly audited in the past and gaps in record keeping meant we could not see if all the necessary checks were in place for all staff. This was being addressed by the new manager. The same applied to staff training and supervision of practice. Records were not up to date but training was being refreshed and schedules were in place for future training and supervision.

People's health care needs were monitored and promoted. People had sufficient to eat and drink but the monitoring of this was poor.

People's records were not always up to date and we have made this a breach of the Health and Social Care Act 2008. The manager is aware and is working with their staff to improve upon this situation?

The service had a lack of effective systems to monitor the effectiveness and safety of the service it provides to individuals and the service as a whole. This has been identified as a breach of the above Act.

There was excellent engagement with health care professionals but less so with the wider community or with people and their families in terms of their preferences of care.

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

The service was not always safe.

Risks to people's safety and welfare were reduced by staff who were familiar with people's needs and able to identify changes in their needs. However people's records did not accurately reflect actions that should be taken by staff. Care plans and risk assessments were not sufficiently informative, or up to date.

Staffing levels were appropriate to needs but the redeployment of staff reduced the amount of time staff had to spend with people. The service did not have any systems in place to judge if they had the staff they needed in line with people's dependency levels.

People felt safe and staff were aware of their responsibilities for reporting any concerns. However records did not show that staff were proactive in raising concerns or that the management used information of concern to improve the service. Poor quality assurance systems meant that poor practice was not being identified or information of concern acted upon.

Staff recruitment was adequate but gaps in staffing records meant we could not assess if all staff had been recruited in line with the services recruitment policy.

Medicines were administered by staff trained to do so but medication audits did not always show how short falls were addressed in a timely way.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff promoted people's choices but people's preferences were not clearly recorded. It was not clear if everyone had capacity to make choices or how the service involved relatives particularly when they had enduring power of attorney for care and welfare

Staff were supported through induction, training and support but records did not reflect that all staffs training was up to date. Staff supervision was not firmly established so we were not clear how

Requires Improvement ●

staffs performance had been monitored.

People were supported to eat and drink in sufficient quantities but this was not being accurately recorded so we could not be assured risks of malnutrition /dehydration were fully mitigated. The food provided to people was of high quality and the chef knowledgeable about people's dietary preferences. .

The service had excellent engagement with other health providers and worked cohesively to ensure people's health was promoted and sustained.

Is the service caring?

Good ●

The service was very caring and staff engagement with people and with each other was positive. This has the hall marks of an excellent service which was evident in the care provided to people.

People had the last restrictive environment and were promoted to do what they could for themselves to help keep people mobile and independent.

People were offered choices on a day to day basis round food and activities but we saw poor evidence of people's involvement in their records and with wider issues affecting the service.

Is the service responsive?

Requires Improvement ●

People were happy at the service.

Activities were provided but the range and scope of activities were limited by the amount of time allocated to them. People's personal histories were not completed so it was difficult to see how the service continued to promote people's opportunities and engagement with the community.

People's needs were largely met because the service had a regular staff team who were familiar with people's needs. However people's records did not reflect the high standards of care people were receiving.

Comments and concerns had not been a clearly established way of monitoring and improving the service as there were very few records. This has since been addressed by the manager.

Is the service well-led?

Requires Improvement ●

The service has not been well led.

The recent change in manager has led to a number of positive changes in the service and we are confident they will continue to make improvements and rating of this service. They are being supported by the provider. There was a lack of systems in place to assess and judge the effectiveness and quality of the service being provided in line with currently legislation and standards in care.

A lack of recording meant we could not judge how risks to people's safety were being mitigated or if staff were providing care in accordance with people's wishes, preferences and needs.

Staff records also had gaps and did not show that staff had up to date knowledge and the required skills to meet people's needs.

The links the service has established with other health care professionals is exceptional and means people's health is promoted. The links the service has with the rest of the community are poor and need to be developed further in the interest of people using the service.

Fairland 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.

The inspection took place on the 16 and 20 December 2016 and the first visit was unannounced.

The team consisted of two inspectors on the first day and one on the second. As part of this inspection we spoke with ten people using the service, six staff including the manager, the owner, catering staff, maintenance and care staff. We also spoke with a visiting health care professional and two relatives. We reviewed records, including four care plans, staffing records and maintenance records. We observed care across the day particularly at lunch time.

We reviewed information we already held about the service including the last inspections report and any notification/information received about the service. Notifications are important events affecting the well-being and or safety of the service which they are required to tell us about. We had received a provider information return form this provider which gives us important information of how they are meeting regulations.

Is the service safe?

Our findings

Risks to people's safety were managed but gaps in records and poor evaluation of people's needs made it difficult for us to assess how effectively staff did this. Staff demonstrated a good knowledge of people's needs and where possible mitigated risks to people through the use of equipment, personal alarms, door and bed sensors. Beds were at their lowest settings where there was a risk people could fall out of bed.

People were encouraged to eat and drink but we noted some people were identified at risk of losing weight unintentionally or had lost weight recently. They did not have food and fluid charts in place and everyone was weighed monthly which was not a proportionate approach to risk. In addition there was not clear oversight of people's weights and risk of malnutrition. The cook was not able to tell us if anyone was currently losing weight and neither was the manager. Some people had not been weighed in the last month for various reasons but this had not been addressed by staff

We found people's records did not accurately reflect their needs or risks associated with their care. This meant we could not be assured that people received the continuity of care they needed or that all staff were following an accurate plan of care. For example we looked at one care plan which had some basic information recorded but it was not signed or dated so we do not know if the information was still relevant. Gaps in recording did not help us clearly see how risks were being monitored. The person was identified at risk of weight loss; however there was nothing recorded for their food likes or dislikes, there was no record of food intake and no risk assessment re: the risk of choking despite a recent referral to the speech and language team and a visit which identified the need for fluids to be thickened.

Other care plans showed similar gaps. Staff confirmed no one was currently being weighed weekly despite some people being at high risk of unintentional weight loss. We could not see how this was being effectively monitored and there was no weight tracker to help the manager identify who should be weighed weekly. Another person had a nutritional care plan but this was not linked to their current weight and they had not actually been weighed for several months. The plan said what staff should do to promote the persons weight to keep it at an acceptable level but it was not clear if staff were following these actions as there was nothing recorded. We saw falls risk assessments in place and where a risk had been identified people did not have a personal handling profile place and no guidance for staff about how the person should be supported with transfers.

We saw for another person they had a high risk in terms of poor skin integrity but there was no plan for staff to follow in terms of reducing the risk. This record also showed the person could be incontinent and we could not see a continence assessment or what continence products they needed, including size which is important in terms of preventing leakage and damage to the skin.

Care plans and risk assessments were being reviewed but not monthly as the care plan suggested. Some care plans had not been reviewed for two months despite people being at high risk. We also noted that where people had a change of need there was not a clear record. For example following a person's discharge from hospital we were unable to see how the person had been or if amendments were needed to

their care plan and risk assessment.

This is a breach of Regulation 12 (1) (a-b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

A number of people had a do not attempt cardiopulmonary resuscitation forms in their care plans. This information needs to be easily retrievable in an emergency. We recommend the information be collated and held in the office so staff could refer to this quickly.

Other records were collated to show any accidents and incidents which had occurred for the preceding month. The records were comprehensive and included an account of the incident, the date, person involved and details of any action that had been taken. There was also an accident trend analysis which included the type of accident, type of injury sustained, cause of the accident, time of the accident and the area that it occurred. It was a very clear and comprehensive account but was only in a paper format each month and therefore not used to gain a clear oversight of the service and the information collected was not effectively being used to mitigate future risk.

There were systems in place to ensure people's safety such as fire drills but these were not comprehensive. The last one recorded was 23 March 2016 and was for the night staff only. Fire alarm testing showed only one location was tested each week. Emergency lighting and extinguishers were tested weekly but there was no test record for November 2016. We saw that the fire safety certificate was in date – expiry date April 2017. Water testing carried out but the sentinel taps tested monthly (this is the tap closest to and furthest from the boiler) therefore it is always the same taps tested. There was no record of testing in November 2016.

People told us they felt safe and there was information around the service about how people or their relatives could raise concerns and information about recognising and reporting safeguarding concerns. People told us they felt safe living at the service and staff felt able to raise concerns as necessary. Staff and people using the service had confidence in the care given and received. One person told us, "I have no concerns about safety." Staff spoken with had received training but in the absence of detailed, training logs we were unable to see if all staffs knowledge was refreshed at regular intervals. Staff knew how to raise concerns but spoke about raising concerns internally and only mentioned the role of external agencies when prompted to do so. The manager was not able to find any safeguarding concerns raised, the last record being in 2011. It would be unusual not to have any raised safeguards by or about the service in five years and we contribute this to poor record keeping and a lack of provider oversight

There were sufficient staff to meet people's needs on the days of our inspection. There were 29 people using the service and one person in hospital. A new person was admitted during our inspection. People told us staffing was adequate and staff responded appropriately if they needed help. People also told us staff were always busy and did not have time to just sit with them or stay and chat. This is what we observed throughout the days of the inspection with people being engaged very little other than when being assisted with their care and at meal times. Staff told us staffing levels were alright most of the time. Staff told us most people were up by eight am and started to be assisted to bed following tea. We were unable to establish from people's records if this was their choice.

The staffing rotas tallied with the actual number of staff on duty. This included four care staff in the morning and evening and three in the afternoon reducing to two at night. A number of staff were seniors with additional responsibilities mainly for the administration of medication. The manager was supernumerary. The rotas showed some fluctuation of staffing levels and this was due to availability of staff rather than

people's dependency levels. The provider did not have a dependency tool they currently used to determine how many hours support each person needed so we were unable to see their justification for current staffing levels and whether staffing hours were sufficient. A new admission on the day of our inspection gave us concern in regards to night staffing levels as this person needed a lot of support/supervision. This had not been considered when deciding whether their admission was appropriate. A further concern for us was that staff were being deployed into other roles which meant less time was available to meet people's care needs. Examples included care staff doing laundry and activity staff doing care. Since our inspection the manager has confirmed they have employed a laundry assistant.

We recommend that the provider review current staffing levels in line with people's needs and uses a tool to assess needs. We also recommend sufficient hours are allocated to meet people's social needs.

Medicines were administered by staff trained to administer medicines and assessed to be competent, but we identified a couple of areas which need addressing to help ensure people receive their medicines as prescribed. There were two medicines trolley, one for upstairs, one for downstairs which were well organised. Medicines were either in individually labelled blister packs or in original boxes individually named. Creams and medicines were dated when opened and drug temperatures were kept to ensure these were stored at correct temperatures. People had a medication front sheet which included a photograph and any allergies. There were no details of medicines people were taken other than on the Medication recording sheet and no specific instructions around how the person liked to take their medicines. However separate risk assessments were seen for people in relation to their medicines. We recommend these risk assessments are kept within the persons separate record and not collectively in a folder so they are easily accessible and can be followed when the person is administering medication. . We looked at a sample of risk assessments and saw one person liked to be left with their medication and staff said they took it straight away. However staff were then signing for their medicines without observing it had been taken which is not appropriate. People had cream charts in their rooms which indicated the site cream should be applied. The service undertook monthly medication audits which did not include a review of cream charts and this should be undertaken to ensure appropriate administration of creams.

No one currently was taking their own medication or receiving their medicines covertly. Staff told us one person did on occasion refuse their medicines but this had been addressed and staff had referred this through the GP.

Stock checks were completed monthly and there were established policies and procedures for administering medicines. However not all staff who were responsible for administering medication were sure of the actions they should take if they made or identified a medication error. Some staff thought this might go on an incident sheet others were not certain. The service had a good relationship with the pharmacist and said scripts for medicines could be obtained the same day where necessary, so treatment could start quickly such as the use of antibiotics for infection.

Audits completed monthly did not contain much information about what had actually been audited. The senior told us every single medication record would be checked and cross referenced with medicines in stock but it was not clear from the audit if this happened in practice. Where things had been identified we could not see if they were addressed immediately and by whom or if they were not checked again until the following audit. This is a long delay. We checked a sample of drugs against what was in stock and what was recorded on the MAR sheets and these tallied. The management of controlled drugs was satisfactory. The supplying pharmacist was said to have completed a recent audit but evidence of this could not be found.

There were systems in place to ensure only suitable staff were employed. Gaps in staffing records had been

identified by the current manager and was being addressed. We audited two staff files and saw appropriate checks were sought before the employment of new staff. This helped to ensure they were suitable to work with older people and had the necessary skills and attributes. Job and character references were taken up as well as a disclosure and barring check to ensure they had not committed an offence which might make them unsuitable to work in care. Application forms included their work history and education. Checks on the persons identify, work status and proof of address were also obtained. Interview processes were being tightened up with interview questions around job specifications and job descriptions. Job descriptions for staff had not been updated and did not accurately reflect the job staff were being asked to do and the manager said they would update these.

Is the service effective?

Our findings

Staff had some understanding of the Mental Capacity Act 2005 and had received some basic training. Staff promoted people's choice and believed everyone to have capacity to make decisions about their care and welfare in an environment at least restrictive as possible. There were a number of Deprivation of Liberty safeguards in place for people who would not be safe to leave and were detained for their own safety. The manager said they intended to review this and see if any further applications were required. We saw some recorded decisions in people's care plan and people's consent for treatment in relation to medication. One person had signed a consent form to have a flu jab but when we asked the family about this they told us their relative was not able to make decisions or retain information and they had not been consulted. They had enduring power of attorney for care and welfare.

This is a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Consent.

We were not assured that all staff had the necessary competencies and skills for their role. This was due to records not demonstrating that all staff had received regular and updated training or been adequately supervised throughout their employment. Previous audits on staff files had not been undertaken. The manager was putting into place a training matrix and auditing staff records to see where the gaps were. This would enable them to ask staff for evidence of training they had done. The manager showed us training was completed using both external training and using workbooks and videos. Training was being booked to ensure staffs training was up to date.

Training around people's specialist needs was being provided with good input from district nurses. Staff told us they had completed training in nutrition, diabetes and wound care and the service was developing a dementia coach who would take a lead in supporting people with dementia and helping staff meet their needs effectively. In addition the manager had up to date train the trainer qualifications which enabled them to complete some training in house.

The manager had put a supervision schedule in to place and had already planned to or had carried out staff supervisions. The manager told us they were going to introduce a form of concern to be used as part of supervision if they observed any poor practice which would then be formally recorded and steps taken to encourage improving practice. Staff induction processes were in place and were sufficiently robust. Staff new to care were undertaken the care certificate a nationally recognised induction programme for care staff. Where staff had already done care work, evidence of previous skills, and training were taken into account and cross referenced with the key competencies detailed in the care certificate work book to show staff had already covered this

Staff were supervised when first working at the service for about a week and the person observing them would sign off what they had shown them and observed them doing as well as the person being inducted. This provided a comprehensive record. In addition we saw that over half the staff had completed additional qualifications in care and many were established, experienced members of staff. There were a high number

of senior staff who did not have specific responsibilities other than leading the shift and doing medication. The manager was in the process of doing a skills audit and deciding lead roles.

People were supported to eat and drink in sufficient quantities for their needs. We observed lunch which was provided in a number of different areas of the service giving people the choice in where they ate. The food was well presented and homemade. The chef was very experienced and knowledgeable about people's needs. They told us about individuals and what they liked to eat. They said for example one person loved cockles and these were purchased on their behalf. They knew how to promote people's calorie intake and about people's specific dietary needs. There was a seasonal menu, twelve days of Christmas with seasonal treats. People had a copy of menus in their rooms. People told us that they enjoyed the food and that there was always plenty of it. We saw that people sitting in the lounge areas had drinks that were accessible and that snacks were offered to people in the morning and the afternoon. One person told us, "They are very good like that; you can always ask for something else if you fancy it." In the conservatory there were eight people sitting around one table was very sociable with people chatting and laughing together. The other table consisted of three people and in the main they did not speak to each other. Staff asked people if they required assistance before providing help to cut up food.

Everyone was independent. Staff popped in and out to check how people were. Drinks were accessible on the table as were condiments. There was a choice of pudding brought in on a trolley and people were able to look at it to assist with choice. One person was unable to decide on which pudding to have and so had a little of both. They told us, "That was very nice. I enjoyed that." And "We'll never die of starvation here! They are always such big portions!" There was plenty of choice offered to people and plenty of laughter. One person spoke about how they had friends coming to visit them for lunch the following day. Family members told us, they were welcome to join in for a meal and the chef said they did not charge for food but asked visitors for a donation. Visitors were welcome to make themselves drinks which were nice but we were concerned about cross infection practices in the kitchen as staff and visitors came and went without sufficient attention to hygiene.

People received on-going support with their health care needs. We spoke with some family members who told us that staff always kept them informed of any changes to their family member's health. They said annual check-ups were carried out and organised by the service. They said the nurse was there all the time and they had regular visits from the chiropodists and more recently the optician. They were confident that their health care needs were being met.

The manager told us that the service had an "outstanding relationship" with the District Nursing team and that the service was well supported by the local GP surgery. People that we spoke with told us that the staff were proactive in seeking medical advice when it was needed, and that they were confident and felt reassured by the support that was provided by the GP and the District Nurse's. The Nurse practitioner visited the service every Thursday. They described the atmosphere as "Always calm, always peaceful, feels friendly." They told us that they felt that in the main the staff were regular and they always tended to see the same faces. They described the new manager as "excellent" and felt that they knew people well and were always available to assist them on their rounds. They went on to describe the communication in the service as very good. There was a book which staff used to document any concerns and then they were discussed when they visited e.g. staff had handed over that a person was choking when eating and they had referred them to the speech and Language Team for an assessment. They told us they always fed back any concerns to the GP for their input if required. Care plans showed input from opticians, dentist and medical professionals.

Is the service caring?

Our findings

The staff we meet demonstrated a warm, caring attitude to people they supported. They were able to joke with people and it was clear they had good, meaningful relationships with them. The manager told us "The care that the residents get is exceptional." The manager also told us "I always say to staff, this is people's home. We need to remember that it is so important." This was clear in the way staff conducted themselves, knocking before entering people's rooms and promoting choice and independence. . We saw staff enabling people and promoting their independence with day to day skills. For example people were encouraged to mobilise and exercise. People had the equipment they needed to facilitate their independence.

We observed people and listened to their experiences. One person told us, "I can't complain about anything really. They are all lovely girls." People told us that staff were always happy and smiling and that they were able to have a giggle with them which helped them to feel comfortable and at ease in their presence. One person told us about surgery they had received and the aftercare given to them by staff which helped their recovery. Some staff had worked at the service for many years and had got to know people well. One staff member told us, "It's lovely knowing what people used to do." Relatives told us, "staff are always welcoming and friendly. "

Everyone that we spoke with told us that staff were too busy to have the time to sit and chat with them and we observed this with people sitting for most of the day. Some people had family supporting them others had stuck up meaningful friendships but some spent the majority of their time in their room and activities were restricted to afternoons.

People that we spoke with told us that they were able to choose when they got up and when they went to bed. We saw that people were dressed individually and people told us that they chose what they were going to wear each day. On the day of our inspection people were having their hair done and everyone was well groomed. There were no odours throughout the service and people looked well cared for. The environment enabled people to move around freely and chose to sit and socialise or sit quietly with some privacy. People had access to the garden. One person told us about the visiting wildlife whilst another felt connected as they were able to see the coming and goings outside.

A residents meeting had recently taken place, people told us that they did not happen frequently. "I can't grumble at all. You can do what you like." Meetings were not firmly established and people appeared to have little opportunity to input into their care records as there was no evidence of consultation. However it was clear that in practice staff did give people choices and facilitated people's individual needs. This was clearly evident at lunch time.

Is the service responsive?

Our findings

We looked at people's records to ascertain how their needs were identified and planned for. Initial assessments were usually carried out by the service. However on the day of our inspection an emergency admission occurred and at the point of admission the service had very little information about the person's needs. We re-inspected the service four days later and looked at the information in place for this person. There was not a full care plan just some very basic details, daily notes and a nutritional assessment. There were no risk assessments and we were aware the person was unsteady on their feet. The information did not tell us, what the person's needs were or what actions staff should take to meet their needs or mitigate risks. However the staff had put in place sensor alarms which would alert them if the person was on their feet. In relation to their nutritional care plan there was no monitoring of this in terms of what they were eating and drinking during their stay so it was difficult to see how staff could evaluate the care given.

This is a breach of Regulation 9 (3) (a-i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

In addition we found other people's records lacked detail and daily notes did not reflect the care staff were giving. There was no information about people's care needs at night or any specific guidance night staff should be aware only vague instruction like, 'Check regularly.' Monthly evaluation of need was identified as necessary by the service but this was not always happening and we identified gaps in recording. Some records were not dated or signed which meant we could not see if the information was still relevant and up to date. There had been no previous system of audits for care plans to ensure they were accurate and up to date. The manager has since introduced a key worker system giving a named member of staff the responsibility for oversight of the persons care and point of contact for the family. They had already identified where people's needs had changed over time and had referred people to appropriate services.

Care plans were not personalised sufficiently clearly outlining people's preferences of care. Information provided was ambiguous and we could not see how information had been collated. For example: 'Needs support with washing and dressing.' This does not state what support is required or what the person could do for themselves thus promoting their independence. There was limited information about people's life history, experiences and family which is particularly useful in given staff an insight and helping people stay connected. The manager told us that after new year they were developing passports for people. This means developing a personal profile in sufficient depth which would enable all staff to know more about the person, what's important to them and to enable them to provide care and support which is personalised. We noted that there was little currently in terms of supporting staff to support people who were reluctant to accept help around their care needs or potentially could become distressed when being assisted. The personal profiles should help staff more effectively help people manage their anxieties.

Feedback from people using the service was positive. One person told us, "It's exactly what I needed; they allow me to do what I want. There's a lot of choice, I don't always join in but I am always invited. "Another told us, "I came here for respite care and didn't go back."

There was limited activity to engage people to promote their well-being and mental health. An activities co-ordinator was employed for 25 hours a week. One person had a timetable of activities for the week in their bag; we saw that this included bingo, nail painting and Christmas crafts. One person told us that local schools had visited the service and sung choirs and that sometimes external entertainment was organised. We spoke with a person who had recently moved into the service. They told us that they did not remember being assessed by the service before they came to live there and that since living there they had not had a discussion with staff about their likes and dislikes or how they preferred their care to be provided. The person did not perceive this to be a problem because they were very independent and so needed only minimal support from staff.

Activities were provided and there was a list showing afternoon activities Monday to Friday afternoon. The programme was inflexible as it did not show activities taking place in the morning/evening or at the weekend. There were a number of external events which had taken place, including: music for health, zootastic and carol singing. The activities co-ordinators hours had not been protected and this meant that sometimes planned hours were reduced even further and there were no volunteers and limited engagement with the local community which restricted people's experiences.

Since coming into post the manager had introduced a complaints log book. Prior to this there was no clear process for recording complaints and concerns. There are clear policies for staff to follow. We reviewed the only recorded complaint recorded which showed actions taken were responsive and within the agreed time scales.

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Is the service well-led?

Our findings

There was a new manager in post who was not yet registered with the Care Quality Commission. They told us about their experience which was relevant to their post. They said the previous registered manager had left before they started and there had been no overlap or induction provided. However the service had an experienced deputy manager and a number of seniors who had been at the service along time and knew people well. We judged that the manager had sufficient oversight of the service but improvements were required in the way records were kept and how the service analysed and judged the effectiveness and quality of its service. The absence of robust quality assurance systems meant that we could not see if the service was effective or if risks to people's health and safety were being appropriately managed or if the service was run in the interest of people using it. We identified gaps in people's care records so could not see if people's needs were being correctly identified or if there was an effective plan for staff to follow to ensure people's needs were being met. Risks were managed by staff but this was not always effectively recorded and gaps in recording meant we could not always see if staff had taken timely actions.

The service was given a three star environmental rating and has since started to upgrade the kitchen and had undertaken remedial works within two weeks. The paperwork was found not be up to date and has now been put in order. This had not been identified previously by the service which is further evidence of ineffective quality monitoring systems. Furthermore gaps in staffing records had not been identified by audits further demonstrating poor auditing systems.

This is a breach of Regulation 17 (1) (2) a-d of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care

People spoken with told us the previous manager was held in high regard but after they left the service did not have a manager for a while. We were confident in the new manager as they had already identified a number of key changes they needed to make and had familiarised themselves with the needs of people using the service. People using the service knew who the new manager was and commented on the difference they were making. For example, one person told us about the re-decoration of the service. They said residents meetings had been organised and that staff seemed happier. Staff told us it was a good place to work. One staff member said, "The manager listens and is responsive to new ideas, we have regular staff meetings." Another said, "Their door is always open, there's a good rapport." We observed that the manager knew people well, during the inspection they were clearly visible around the service and greeted people by name when they stopped to talk with them.

The manager told us the owner/registered provider who also had two other services was very supportive and had responded to any request they had made. Since coming into post the manager had already had a lift installed and the service was being redecorated throughout. The manager told us they had contact with the managers of the other services but this was not formalised and there was no evidence of how they meet regularly and shared good practice across the three different services. The manager was aware of what needed to be done at the service and agreed the documents needed to be put in order but said they were happy with the ethos of the service and the care provided to people. They told us visitors and health care

professionals came and went as they pleased and they promoted an open door policy.

The service had an annual quality assurance survey they sent out to staff, people using the service and their visitors. People we spoke with and visitors were aware of this and had been asked to participate. They were less clear of what happened as a result of their feedback. We saw feedback from surveys was mainly positive. People spoken with were not aware of their care plans or the review of these. The manager is in the process of looking at the way care plans were being reviewed. We asked people who were able to tell us about their care needs so would equally be able to contribute in a review. Families spoken with said they had not participated in a review in the last year or more and there was no evidence of people's involvement within the care plans inspected. Two family members told us there were no relative meetings but a face book page which kept them up to date.

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 People's needs were not always fully assessed or an appropriate plan put in place to show what actions staff were required to take to meet people's needs and keep people safe. Records did not show what care was provided or demonstrate care plans were updated as required.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always being appropriately sought or people's wishes and involvement in decisions recorded.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always take steps to assess and mitigate risks to people health, safety and well being.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have adequate systems in place to assess, monitor and improve the service they were providing to ensure it meet people's needs and provided a safe service.

