Mr & Mrs A D Hodgson

Appledale Cottage Residential Home

Inspection report

Bagley Marsh, Ellesmere
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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

Overall summary

This inspection took place on 1 June 2015 and was unannounced.

Appledale Cottage Residential Care provides accommodation and personal care for older people and people living with dementia for a maximum of 10. On the day of our inspection nine people were living in the home.

The home had a registered manager in post who was also the provider. They were not present for our inspection. 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.

People told us that they felt safe living in the home. However, not all the staff were aware of how to protect people from potential harm. The provider did not

Summary of findings

understand how to protect and uphold people's human rights. Where decisions had been made on people's behalf it was not recorded why this had been done and why they were in their best interests.

People told us that they did not have to wait a long time for staff to support them and there were enough staff on duty to care for them. People were supported by staff to take their prescribed medicines and we saw that medicines were stored and recorded appropriately.

People were supported by staff who had not received regular training to ensure they had the skills to care for them properly. People told us that they were happy with the meals provided but they did not have a choice of meals. People told us that they had access to other healthcare professionals when needed.

People told us that staff treated them well but they were not involved in planning their care. We saw that people's right to privacy and dignity was respected.

People were not involved in the assessment of their needs or supported to pursue their hobbies and interests and they did not have access to facilities within their local community. Not everyone was confident to share their concerns with the provider and the complaints procedure did not tell them who or how to share their concerns.

The service lacked effective leadership and the manager was unaware of their responsibilities of ensuring people received a safe and effective service and there were no systems in place to drive improvements.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

There were enough staff on duty to care for people but not all staff knew how to keep people safe from harm. Staff had access to risk assessments that told them how to support people safely and people were provided with the relevant support to take their medicines. Accidents were monitored and action taken to reduce the risk of it happening again.

Requires improvement

Is the service effective?
The service was not consistently effective.

People's human rights may not be protected or upheld because the manager did not know how to do this. The care and support people received could be compromised because staff did not always have access to training to ensure they had the skills to care for them.

People told us that they did not have a choice of meals but enjoyed the meals provided to them. People had access to healthcare professionals when needed.

Requires improvement

Is the service caring?
The service was not consistently caring.

People were not involved in their care planning but were happy with the care provided and said that staff did respect their privacy and dignity

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People were not involved in the assessment of their needs and were not supported to pursue their hobbies and interests. Not all people were confident about sharing their concerns with the provider.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

The leadership within the home was not robust in driving improvements to ensure people received a safe and effective service. The provider had not addressed all the concerns identified at the previous inspection. People were involved in meetings that gave them the opportunity to tell the provider about their experience of using the service.

Requires improvement

Appledale Cottage Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 June 2015 and was unannounced. The inspection team consisted of two inspectors.

As part of our inspection we spoke with the local authority to share information they held about the home. We also looked at the information we held about the provider and the location. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. The provider completed a Provider Information Return (PIR). 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 our inspection.

On the day of our visit we spoke with five people who used the service, the deputy manager and two care staff. After the visit we spoke with the registered provider by telephone. We looked at five care plans, risk assessments, medication administration records and accident reports. We observed care practices and how staff interacted with people.

Requires improvement

Is the service safe?

Our findings

One person said, “The staff are very good and that makes me feel safe.” Another person told us, “I feel safe due to the atmosphere and the people around me.” Another person said, “I feel safe here and that my possessions are safe.” We spoke with a care staff who knew how to keep people safe. They were aware of their responsibility of sharing concerns of abuse with the manager and other outside agencies to protect people from harm. The person in charge was unaware of the safeguarding procedure or how to protect people. They were unaware of their responsibility of sharing concerns of abuse with the local authority. We found that where there had been an allegation of abuse, appropriate action had not been taken to protect the person. This meant that people could not be confident that they would be protected from potential harm.

A member of staff told us that they had access to risk assessments and we saw these in place. Risk assessments told staff how to safely assist people with their mobility and what equipment was required to do this safely. We saw risk assessments in place that told staff how to reduce the risk of pressure sores and how to ensure people’s safety whilst in the garden. We saw that these assessments had been reviewed regularly to reflect people’s changing needs. The staff member we spoke with was aware of the risk to the individual and how to support them to ensure their safety. A record of accidents was maintained and we saw that these had been monitored to find out if there were any trends. The person in charge said that they had not identified any trends but action would be taken if they had to reduce the risk of a reoccurrence.

People told us that they did not have to wait a long time for support. One person said, “The staff are always here when you need them.” We saw that staff were nearby to assist people when needed. Staff and the person in charge were confident that there was enough staff on duty to meet people’s needs. The person in charge told us that recruitment practices ensured that safety checks were carried out before staff started work at the home. This was confirmed by a staff member and the staff files we looked at. These safety checks ensured that staff were suitable to work in the home.

People required support to take their medicines and this was carried out by staff. Discussions with people and the medication administration records we looked at confirmed that people received their medicines when they needed them. We saw that some people had been prescribed medicines to manage their pain on a ‘when required’ basis. These medicines had not been administered for a while and the person in charge said that people would ask for them when they needed them. Medicines were stored in a locked cabinet but we saw that the keys were left on top of the cabinet and were accessible to people who used the service. This placed people at potential risk of harm if they obtained medicines that had not been prescribed for them. The person in charge told us that the keys were always left unsecured and they were unaware of the potential risk to people.

Requires improvement

Is the service effective?

Our findings

At our previous inspection in July 2014, the provider did not have any arrangements in place to ensure people had access to routine health screening. At this inspection people told us that they were able to see their GP when needed and had access to a dentist, optician and chiropodist. Records had been maintained of when healthcare professionals had visited people.

The person in charge told us that all the people who used the service were able to consent to their care and treatment. Discussions with the person in charge and the care records we looked at confirmed that some people had a diagnosis of dementia and that their understanding at times varied. The person in charge was unaware of when a mental capacity assessment should be carried out. For example, one care record showed that when the person displayed behaviours that challenged staff, they were taken to their bedroom. This decision had been made by the provider and the person's relative. The person in charge said that the person lacked mental capacity to agree to this and confirmed a mental capacity assessment had not been carried out or why this decision had been made on the person's behalf and why it was in their best interest. The person in charge told us that no medical practitioner had been involved in this decision and were unclear if the person's relative had the authorisation to agree to these decisions.

The person in charge told us that they had not explored whether an application for the Deprivation of Liberty Safeguards (DoLS) should be submitted to the local authority to enable them to legally restrict the person's liberty. This meant people's human rights may not be upheld as required by the law and their freedom restricted.

The person in charge said that people were free to leave the home if they wanted to but no consideration had been given to whether people would be safe to do so without support and this placed them at risk of potential harm.

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

People were supported by staff who did not have access to regular training, the person in charge told us that not all staff had received up to date training in safeguarding, fire safety, food hygiene and moving and handling. We spoke with one staff member who had a good understanding of safeguarding. We observed staff assist people with their mobility in a safe manner. However, if staff do not receive regular training this may result with them not having the up to date skills to care for people properly. The person in charge told us that staff were provided with supervision and this was confirmed by a staff member. The provider's recruitment procedure ensured that new staff were provided with an induction and this was confirmed by a staff member. Access to induction ensured that staff were supported in their new role to provide an effective service.

People told us that they were happy with the meals provided. One person said, "The food couldn't be better." People told us that they were not provided with a choice of meals and this was confirmed by the person in charge. A one week menu was in place and this was repeated over three months. People told that they did not have access to snacks throughout the day but they were never hungry. We spoke with the provider after our inspection who told us that they did not have the funds to offer people a choice of meals. This meant that people could not be assured that their dietary preferences would be met. People told us that they had access to drinks at all times and we saw staff offering them drinks throughout the day.

Requires improvement

Is the service caring?

Our findings

The person in charge told us that people who used the service had capacity to consent to their care and treatment but we found that people were not involved in their care planning. The people we spoke with were unaware of their care plan but one person told us that staff did ask them if they were happy with the care provided. Another person said, “You couldn’t be looked after better.” Another person said, “If I need help someone will come and help me.” One person told us that they had discussed with the manager their end of life care and said, “I would like to stay here to the end of my days.” We spoke with one staff member who said they had access to care plans and they were aware of people’s care needs and how to meet them.

One person said, “Staff treat me very good and are obliging.” Another person told us about the support they required with their personal care needs and said, “I am very satisfied.” We heard staff talking to people in kind and gentle manner and provided them with support when needed. One person was uncomfortable with the inspection team being in the home and we heard a staff member reassure them.

People told us that staff respected their privacy and dignity. One person said, “Staff treat me and my visitors with respect. We saw that people were taken to a private area when they required support with their personal care needs. A staff member said they always spoke to people in a discrete manner when discussing their personal care needs. We saw that bedroom doors were fitted with a lock to ensure people’s privacy and that their personal possessions were safe.

Requires improvement

Is the service responsive?

Our findings

We were told people were involved in the assessment of their care needs but this was not confirmed by the people we spoke with and care records did not provide evidence of this. Where people are not involved in the assessment of they needs they may not receive care and support the way they prefer. We saw people sat in the conservatory where some talked amongst themselves and others slept until staff woke them to offer them a drink. One person told us that staff did not take them out but their family did. They were unaware of any arrangements in place to support them to go out. They said they used to enjoy shopping and going to church before they moved into the home but they were unable to do this now. The person in charge told us that people did not show an interest in social activities outside of the home. There were no activity provisions for people either inside or outside of the home. We spoke with the provider after the inspection who said that people did not show an interest in accessing leisure services within their local community and arrangements were not in place to provide social activities within the home.

One person told us that they had never made a complaint but felt confident that if they did the provider would listen to them and act on it. Another person told us if they had any concerns, "I wouldn't say anything, I would just put up with it." We found that not everyone was comfortable to share their concerns with the staff. For example, we saw a staff member give a person a drink but had forgotten to put sugar in it and the person was reluctant to draw this to the staff's attention. Another person told us that staff often opened the windows that made them feel cold but they didn't complain. This meant people were not confident to share their concerns with the provider. People had access to the provider's complaint procedure but this did not tell them how or who to share their concerns with. The person in charge said that they had not received any complaints.

Requires improvement

Is the service well-led?

Our findings

At our previous inspection in July 2014, the provider confirmed that they did not have any auditing systems in place to ensure that people received a safe and effective service. At this inspection we saw that action had been taken to audit accidents within the home. The person in charge told us that no other audits had been introduced to promote or improve the service provided. This meant that there were no arrangements in place to promote quality and that staff were aware of potential risk that may compromise the care, treatment and support people received.

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

Discussions with people and the person in charge confirmed that people were not supported to maintain links with their local community. People were involved in meetings that gave them the opportunity to tell the provider about their experience of using the service. There was no evidence of any action taken to improve the service in relation to discussions held within these meetings. We saw that quality assurance questionnaires were routinely given to people that asked them about the service they had received and we saw that their comments were positive.

The registered provider was also the manager who worked in the home four days a week; the deputy manager managed the home on the remaining days. The registered provider was unaware of their responsibility of sharing allegations of abuse with the local authority and with the Commission which they are required to by law. The registered provider was unaware of the principles relating to the Mental Capacity Act and the Deprivation of Liberty Safeguards and the impact this may have on people's wellbeing. Appropriate arrangements were not in place to ensure people were able to share their concerns. Arrangements were not in place to make sure that all staff received training so they had the up to date skills to care for people properly and this placed people at risk of inadequate care and support. The person in charge on the day of our visit was aware of when to inform us about important events such as the death of person who had used the service, which they were required to do so by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider was unaware of when to implement the Mental Capacity Act to ensure people's human rights were protected. Decisions made on behalf of people were not in their best interest and this placed them at potential risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider had not taken any action since our last inspection in July 2014, to put in place a robust quality assurance monitoring system to ensure people received a safe and effective service.