Joseph House (Reedham) Limited

Joseph House

Inspection report

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Tel: 01493700580

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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

Joseph House provides accommodation, care and support for up to 40 people with learning disabilities.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 home is run.

We had previously inspected this service in December 2014. We found that the provider was meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the service was rated 'Good'. During this 2017 inspection, we found the registered provider was in breach of six regulations. These included those for person-centred care, mental capacity, assessing and mitigating risk, governance, CQC notifications and staff training.

The registered manager had not always reported concerns to safeguarding to ensure concerns were properly investigated by the responsible authorities.

There were not always staff available to support people when needed, and staff did not all have training relevant to their roles. The staff team had gaps in their knowledge of how they should support people, especially in relation to mental capacity and safeguarding procedures.

People did not have mental capacity assessments completed by the provider to establish whether they were able to make specific decisions or consent to aspects of the care they received. The provider could not be assured that people's rights were upheld.

The registered manager had not always sent statutory notifications to CQC when they were required.

Risk assessments were not always detailed with risks to individuals in line with their own health requirements. Not all information concerning risks to people within their care plans was accurate and up to date. Staff did not always have enough guidance to mitigate specific risks to people.

People's medicines were administered safely by staff who were trained to do so, and medicines were stored securely. Risks to the environment were assessed and mitigated appropriately.

There were recruitment checks in place, however staff application forms had not always been filled out thoroughly.

People's privacy was not always fully upheld because there were not locks on doors of a bathroom and toilet. There was CCTV in operation which people had not been consulted about inside the home. Staff delivered personal care behind closed doors.

Staff did not always encourage choice and independence for people by providing opportunities for people to increase their independence and choose where to spend their time.

People's care plans were not always person-centred with details of individual preferences, and they were not always updated accurately when they were reviewed.

People's interests and hobbies were not always supported on an individual basis, but there was a range of activities and entertainment within the home on offer. People and their families had been involved in planning care for people when they wanted.

People received enough to eat and drink throughout the day and people were supported to access healthcare services.

Quality assurance systems in place had not identified areas where we found concerns, and therefore these needed improving. The registered manager had not always taken action where concerns had been raised to them.

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 consistently safe.

Risk assessments for people's individual health and safety needs were not always thorough and there was not always guidance for staff on mitigating risks to people.

There were not always well trained staff available to support people when they required.

Safeguarding concerns had not always been referred appropriately.

Medicines were given as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not always fully considered because their mental capacity to make specific decisions was not assessed. Best interests decisions were not made and consent was not sought in line with regulations.

People were supported to have enough to eat and drink, and have access to healthcare.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy was not always upheld due to the environment not always having appropriate locks on doors. There was CCTV in the communal areas which people had not consented to.

People's choices and independence were not always encouraged. People were not always supported to have visitors and contact with family and friends when they wanted it.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always individualised and did not always reflect the current accurate needs of people.

There were activities and entertainment on offer but not always in line with individual people's preferences.

The registered manager was not always responsive to concerns raised.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager had not notified CQC when required.

The quality assurance systems in place did not identify all areas for improvement.

There was a positive staff team who worked well together.

Joseph 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 was carried out by two inspectors and an expert-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This was an unannounced inspection.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also 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. Before the inspection, we also obtained feedback from the local authority.

During the inspection, we spoke with five people living in the home and five visitors. We also spoke with five staff members including the registered manager, the medicines lead, and three care workers, one of whose primary role was maintenance in the home. Following our inspection visit we spoke with two further visitors and two healthcare professionals who had recently visited the home.

We looked at the care records and risk assessments for five people and a sample of medicines administration records (MARs) as well as other records relating to health and safety and the running of the home.

Requires Improvement

Is the service safe?

Our findings

During our last inspection in 2014 we found that the service was safe. During this inspection we found that the service was not always safe and required improvement in this area.

In some cases it was difficult to establish how the service was mitigating risks to individuals as the records relating to people's care were not always detailed and accurate. One person had sustained a serious pressure ulcer, and this had not been correctly recorded in the care plan. This meant we could not be sure what the risks to the person were, and how they were being mitigated. The care plan suggested that the person should be supported to reposition every two hours when being cared for in bed, and staff told us how they were supporting the person to reposition regularly. We also saw some records of staff carrying this out as recommended.

The pressure area risk assessment was not thorough in this person's case, and the notes from the district nurse were written in another folder and any changes had not always led to regular updates of the care plan. The notes from the district nursing team had not accurately been reflected in ongoing care planning and risk assessment. A healthcare professional we spoke with who was responsible for the ongoing reviews of the person's pressure area told us they felt the staff were taking the appropriate actions to mitigate risk to the person as the area was healing. However, the care plan did not fully identify the risks to the person and what staff should look out for, and how to monitor any changes in the person's pressure ulcers. The care plan stated the person's skin needed to be 'monitored', but it did not provide guidance on how it should be monitored. There was not adequate information available so that staff would know if the person's skin had changed, and no photographs or body maps of the pressure ulcers. We saw that where recommended, pressure relieving equipment such as specialist boots, cushions and mattresses were being used.

For another person who was at risk of falls due to seizures, a healthcare professional and the registered manager told us that they had put specific measures in place to further mitigate the risks to this person. The healthcare professional told us they felt the actions were appropriate and effective. However, these actions had not been written into an up to date comprehensive care plan and related risk assessment. We saw that accidents and incidents relating to safety had been recorded and the registered manager made aware.

Other risks to people were not fully covered in their daily care plan with guidance for staff. For example, one person was deemed to be at risk of developing urinary tract infections. The care plan and associated risk assessment did not contain guidance for staff on how to mitigate the risks to the person. For another person, the registered manager explained the actions they had taken to further mitigate a high risk of falls, however this had not been recorded in the care plan risk assessment. For another person, they had been referred to the dietician for weight loss, and the associated risk assessment did not contain detail about how the risks were being mitigated until the person was seen by the dietician. The registered manager informed us that the person was receiving extra snacks throughout the day and a fortified diet. However, this information was not in the care plan.

Due to the correct information not being recorded in the care plans, there was a high risk that staff may not

mitigate risks to individuals where possible, especially when unfamiliar agency staff were used. We noted that agency staff were used frequently in the home, however the registered manager told us that they had the same staff returning so that they got to know people's needs.

We received concerns about the manual handling within the home. One visitor and one healthcare professional we spoke with told us that staff did not always follow correct procedures when supporting people to move around. They referred to one person being physically lifted by staff when the person was supposed to be supported using a hoist and sling. Both people told us that they had referred their concerns about these incidents to the registered manager. During our inspection visit we did not observe any poor moving and handling carried out by staff.

Not everyone in the home always had access to a way to call for assistance if they required it. One visitor told us that the person they visited did not always have access to a call bell and it had often been left out of reach. They were concerned that the person did not have a way of asking for help, and they were behind a closed door in their room. This was later confirmed by another person who had visited the person at the home, who told us they had recently visited and noticed that the person had no access to a way of calling for assistance.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all of the staff working in the home had a thorough knowledge of safeguarding and how to report concerns. None of the staff we spoke with were able to give us details about safeguarding, however they were aware that there was a number displayed in the home if they needed to contact safeguarding authorities.

There were risk assessments in place to ensure the safety of the building and environment. Lifting equipment, heating, fire and electrical equipment had been tested. There were systems in place to regularly check that the water system was safe to use, including a legionella risk assessment. We saw that Personal Evacuation Plans (PEEPs) were in place for each person living in the home, which ensured staff would know how to support people in the event of a fire.

There were not always enough staff deployed effectively across the home. Some people told us they felt that they had to be in the same areas as other people so that staff could more easily supervise people. During our inspection visit we observed that most people were seated in the dining room. An activity was taking place in the morning, however once this finished most people remained in the dining room for the majority of the morning. Two people went into the sitting room. There was additional accommodation outside of the main home which consisted of two units. However, people living in these units did not always have free access to their own living quarters during the day. One person said that they had to move from their own accommodation outside of the home into the main home during the day and were not able to return to their room until bedtime.

We found that staff were available during our inspection, but we received mixed feedback from them about staffing levels. The staff we spoke with told us that some days they ran short but worked together effectively to ensure that people's needs were met. The registered manager told us they had some vacancies for new staff as they were using some agency staff to cover a staff shortage. Two people we spoke with gave us examples of when they had needed staff assistance, and one person said on one occasion they resorted to shouting out as nobody came, and another said that they had had to wait up to 20 minutes for their call bell to be answered. During our inspection a visitor told us that they had asked staff to assist a person, and they

did not come, so they asked again over an hour later. We therefore had some concerns that there were not always enough staff available to meet people's needs in a timely fashion.

Staff who were trained to do so managed people's medicines safely and administered them using a comprehensive system. New staff shadowed others on medicines rounds before being observed by more experienced staff and being deemed competent. People living in the home confirmed that staff supervised them taking their medicines, and that they knew what they were taking and what for. There were clear protocols in place to guide staff in administering 'as required' (PRN) medicines. This minimised any risk that people would be given medicines inappropriately or incorrectly. However, we found that when PRN medicines were administered, there was not always a fully detailed explanation when they were given of the reasons for its administration, which is expected in line with current best practice.

Medicines were stored securely at the correct temperature. We saw some prescribed creams left in people's rooms, and alerted the registered manager to this, which they assured us they would address immediately. This posed a risk of accidental ingestion or misuse to some people living with dementia or learning difficulties. We saw that creams, lotions and ointments were dated when opened to ensure they were safe to use.

During our inspection visit, we saw that there were two members of staff administering the medicines, one who stayed with the trolley to check the chart and dispense the tablets into a container. They then handed the container to the second member of staff who gave the medicines to the person. The person with the trolley then signed the chart to say they had been administered. They did not always observe the medicines being taken themselves, so this was not advisable safe practice. We discussed this with the clinical lead who said they would address this.

We looked at a sample of medicines administration records and found that they were detailed with an ID photo of each person on the front of their individual sheet along with information such as how they preferred to take their medicine and any allergies. This helped to minimise errors being made by staff. Staff audited the signatures within the charts daily, which meant that they picked up any potential missed medicines as soon as possible. We saw that this was effective and that the clinical lead discussed any errors with the staff member concerned.

People we spoke with said they felt safe living in the home. One person told us, "I feel safe here and don't need to worry."

The registered manager had some systems in place to check that they employed suitable staff, however there were areas which required improving around these. Prior to people being employed within the home, there were checks in place for the Disclosure and Barring Service (DBS) and references. We saw for some people however, that the application forms had very little information so we could not be assured that the registered manager had fully explored people's employment history and any gaps with them.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in 2014 we found that the service was effective. At this inspection we found that the service required improvements within this area.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager had not carried out mental capacity assessments based on specific decisions for individuals, and therefore we could not be assured that decisions were always made in people's best interests and that people were asked for consent. In the three areas of the home which included the two units, all bedroom doors are alarmed so if anyone were to leave their room at night the duty carer was alerted. Where there were alarms on people's doors, or where people had pressure mats to keep them safe, there were no specific mental capacity assessments in order to ascertain people's consent for these measures to be in place. The home had CCTV in the communal areas and the registered manager had not obtained the appropriate consent from people or ascertained that it was in people's best interests. We saw during our inspection visit that this was being used in communal areas of the home.

Another person had signed their care plan consenting to care, however they were subject to a DoLS authorisation which suggested there was doubt about their ability to consent. This demonstrated a lack of understanding of the MCA. All of the staff we spoke with told us they had not received training in MCA and they were not able to explain its' principles to us.

There were some restrictive practices in place that were not justified or assessed in accordance with the MCA. For example, one person had visitors who told us that they were not allowed to see the person in private and were only able to stay a certain amount of time. The registered manager had told the visitors that this was in the person's 'best interests'. We discussed this with the registered manager who also told us this, however there was no mental capacity assessment around the person's ability to consent and understand information about receiving visitors, and no recorded best interests' discussions or decisions. We were concerned that the registered manager had made this decision without any consultation with relevant people.

Where people had a DoLS authorisation applied for, the registered manager had not always carried out an assessment of the person's capacity to consent or make the decision. Again, there were no best interests decisions carried out in accordance with the MCA. For example, one person had a DoLS applied for, the

person required support to interact with people appropriately. There was no mental capacity assessment carried out and there was no associated care plan. We observed that the person received physical reassurance in the form of kisses and cuddles from a staff member working one to one with them over the course of a day and there was no assessment or consultation with others, with an interest in this person's care, about whether this support was in the person's best interests.

These concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were concerned that only two members of staff had received training in epilepsy awareness, as there were a significant number of people living in the home who had regular seizures and suffered with epilepsy. There were many people who had complex behavioural needs. However, only two members of staff had received training in managing behaviours which some people may find challenging. There was no training in Makaton provided to staff, despite one person living in the home using this to communicate, and no staff had attended training in effective communication which was listed on the training matrix. There were also people living in the home with complex needs associated with pressure care. Only two staff had received training in pressure care.

Staff were not always trained appropriately to carry out their roles. We saw that a member of staff working closely with a person with complex needs had not received MCA training. Only one member of staff had completed MCA training. This staff member confirmed to us that they had completed the Care Certificate where areas of training such as manual handling and first aid had been covered. However, we saw that many staff members employed in the service did not have previous experience in this setting, and were unable to demonstrate knowledge of important aspects of care within their roles such as safeguarding and the MCA. They had not received enough training relevant to the people supported at Joseph House in order to ensure their rights were upheld and their needs were met. Furthermore, we were told by a visitor and a healthcare professional that staff did not always follow manual handling procedures properly.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they felt supported at work and they received supervisions. They also told us they had undertaken the Care Certificate, which is a set of standards expected in health and social care settings. Staff told us about their inductions which included shadowing a more experienced member of staff. We saw that new staff had been assessed as competent in areas such as supporting people with personal care, before they were able to work alone.

People received a healthy balanced diet and a choice of meals to eat. We also saw that people had a choice of drinks which were available to them throughout the day. One person told us, "Food here is really good, healthy diet sort of thing. We're asked every day which choice we want and there's a takeaway every week." Some people received soft or pureed diets as needed. We saw that some people also had thickened drinks to manage their risk of choking, and people received a choice of drinks throughout the day.

People had access to healthcare services and involvement from professionals such as dieticians, chiropodists, district nurses and speech and language therapists when they needed. Two healthcare professionals we spoke with told us that staff followed their recommendations. However we saw in people's care records that recommendations from healthcare professionals were not always used to inform up to date risk assessments and care plans for people.

Requires Improvement

Is the service caring?

Our findings

During our last inspection in 2014 we found that the service was caring. At this inspection we found that the service required improvement in this area.

The environment did not always promote people's dignity and privacy. For example, one person's ensuite bathroom had two doors to it. One opened out into a small corridor and communal lounge, whilst the other door went through to the persons' bedroom. The registered manager told us this ensuite was only used by other people if they were 'desperate', however we noted that there was no lock on the door of the ensuite. Therefore a person could walk in whilst the person was using the bathroom, which did not uphold their privacy. We noted there was also another communal toilet within the home which did not have a lock on the door.

Some practices in the home were not respectful of people's privacy and dignity. We saw, and staff confirmed, that CCTV was being used in the communal areas of the home. The registered manager was unable to provide any records of this or records of consent provided by people. We considered that this was an invasion of people's privacy. Whilst the provider had a policy in place, we could not see that the introduction of CCTV had been subject to proper consideration in line with current published guidance about the use of surveillance and whether other, less intrusive arrangements could be made to enable the monitoring of staff and people. For one person, their visitors told us they were not always able to have privacy with the person they were visiting when they required it.

There were some restrictive practices in place. For example, we saw that on the dining room door there was a notice stating that people could not bring food or drink out of the dining room. We felt that this potentially decreased people's freedom within their home and reflected institutionalised practice. We also saw that people were not always offered a choice of where to eat their meals.

Most people and their relatives were involved as they wished in care planning. People and their relatives knew of the existence of care plans and whilst some relatives were very involved in these, most only had a passing knowledge or interest in them. One relative said, "There's a Care Plan in place – I've worked with them on that. I've been involved in planning care and can visit whenever I want." Another visiting relative also confirmed to us that they could visit when they wished, "I always feel welcome, I'm never afraid to ask, I question why things are done and always get an answer." One healthcare professional told us they felt people and their families were involved in their care planning.

The staff supported people to contact their loved ones by arrangement. One person was supported to skype their family who lived abroad every weekend. Another person was supported to phone their spouse every evening. However, we received mixed feedback about whether relatives were able to contact staff or their relative within the home when they wished. One person's relative said that staff did not answer the phone regularly at weekends so they were unable to ask about their relative or speak to them.

Three visitors, who had an interest in one person's care, told us they did not feel able to visit when they

wished and their times had been restricted by the registered manager. They felt this was not for good reason. One said, "I'm told how long I can spend with [person] and a [staff member] will come and tell me to go." This person told us they did not feel that staff supported people with empathy. Another visitor described the staff as, "Hostile."

We saw caring interactions between staff and people, where staff reassured people when supporting them to eat or take medicines. Staff knew people's needs well and reassured them effectively when this was appropriate. One person told us, "It's a happy, enjoyable place. We've parties for birthdays and Christmases. Staff make me laugh, they understand me really well". One person told us their birthday party had been the day before our visit and staff confirmed that people had enjoyed this. A healthcare professional told us that staff interacted well with people and visitors, and appeared to know people well.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection in 2014 we found that the service was responsive. At this inspection we found that the service required improvement in this area.

Care plans were not consistent. Whilst some care plans we looked at were tailored towards people's individual needs, others were not person-centred. Some were presented in an easy-read format which meant they were easier for those people to be involved with and understand. For some people however, the care plans were not individualised. For example, for one person we saw that the care plans were generic in some areas, and did not contain guidance for staff about how to support that person in the way they preferred. A care plan which outlined supporting people to go to bed did not include aspects of the persons' preferences of how they wanted to receive this support, such as their individual routine. We saw that care plans were reviewed on a monthly basis, but they were not always updated with relevant information.

There was not always consistent guidance in place for staff to support people's emotional wellbeing. In one person's care plan we found details about what language staff should use and how to address the person if they became distressed. We observed that staff interacted with the person, as described in the care plan, during our inspection visit. However, where another person's care plan stated they suffered with anxiety and depression, there were no further care plans to guide staff on how to support the person with these issues. For another person, the service did not demonstrate a consistent approach from staff to establishing boundaries with the person, and staff did not have guidance on how to appropriately support the person with their emotional needs whilst reinforcing appropriate boundaries.

People were not always supported to make independent choices over where to spend their time. One person we spoke with had a room in the accommodation which was external to the main home. They told us they did not feel that they had a choice of where to spend time, telling us, "I can't go back to the Lodge during the day, sometimes when it's noisy it would be nice to go back to my own room to watch TV". However, they told us that they did not mind spending time in the main house, "I'd rather be here than on my own, if you want help they'll help you. I like having people around me". Another person who lived in the same accommodation also confirmed to us that they were encouraged by staff to leave their unit by 9am or earlier to have breakfast in the dining room in the main house and could not go back until their bedtime at 8 or 9pm.

We saw no opportunities for people to enhance their independent living skills, and no care plans around this. We saw that one kitchen in an external house were accommodated was not being used. This meant that the staff were not always optimising opportunities for people to learn skills in independent living.

One relative told us that they felt their family member's interests were not always supported by the home, "[Person] would love to talk with someone about Norwich City FC, [person] loves gardening but doesn't do any here." We saw that there was a broad age range of people living in the home, and that the activities on offer were not always tailored to suit the various age groups and the different interests they may have. For some people, the care plan around activities and stimulation was limited. For one person, their visitor told

us they enjoyed having an Abba DVD on whilst they were on bed rest, however this had not yet been set up and was not reflected in the person's care plan. We saw during our inspection that the people were asked to participate in the same activities throughout the day, including watching a film in the afternoon. We saw that some people were asleep in their chairs when the film was on. There was limited opportunity and encouragement for people to follow their own interests and hobbies throughout the week. We observed one person who became distressed by the morning activity as it was noisy. No other activities were offered even though alternative more suitable activities were documented in the person's care plan.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that on the day of our inspection visit, the home was having a 1940s party, and some staff and people had dressed up for this. They also had an Elvis impersonator visiting. We saw that when the singer was entertaining, several people were up dancing and laughing with staff. One person told us, "I'm happy to be here, I enjoy it. This morning I saw my favourite singer, Elvis, he's here every two or three months."

The registered manager told us they did regular trips out in the home's minibus, including to a social club every Friday. One person was supported to go to College for a few days during the week. Another person told us that trips out were done when staff could find the time. There was no dedicated member of staff for activities at the time of our inspection. People were supported to go on holidays abroad and one person told us about a recent holiday in Mallorca which they had enjoyed.

The home had an exercise machine which was available for people to use, and one person told us they had used this daily and combined with a healthy diet had lost 6 stone. This had had a positive impact on their health.

People's relatives told us they felt staff knew people's care needs well. One relative said, "I'm happy they have a good understanding of [person's] needs." Another said, "Overall, care is very good here. I like what I see and hear, they're aware of what [person] needs."

Several people told us about monthly meetings where people living in the home met and discussed aspects of the home such as food, entertainment and trips out. We saw records of monthly 'talk time' meetings where staff met with individuals and asked them for feedback. They discussed in these meetings things they wanted to do, goals and anything the person wanted to talk about. Goals were then actioned and ticked off when they had achieved it.

Some people we spoke with were confident that if they had any problems or concerns they would speak to staff and they all felt anything would then be dealt with. One person said, "If I had a problem I'd go and tell someone, they'll all help you, any of them." However, some visitors and a healthcare professional told us that they did not feel that the registered manager was approachable and resolved concerns appropriately. There were systems in place to support people to provide feedback on the service such as an easy-read questionnaire available for people to complete.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection in 2014 we found that the service was well-led. At this inspection we found that the service required improvement in this area.

The registered manager had not always reported to CQC when they were required to do so, for example authorised DoLS applications and serious injuries had not been reported to CQC. The registered manager told us they had not been aware of their responsibility to report grade three pressure areas to CQC, or the authorised DoLS applications. There had been two separate grade three pressure areas for the same person which had not been notified.

This meant the service was in breach of Regulation 18 of CQC Registration Regulations 2009.

Contemporaneous records kept in relation to people's care were not always complete and accurate. Risks to people regarding their skin were not always documented and properly reassessed. For example, one person living in the home had sustained a serious pressure ulcer. The pressure ulcer was incorrectly documented as a grade four within the care plan, however we were told by an external healthcare professional that this was a grade three pressure ulcer, and that the person had sustained two different pressure ulcers of grade three. They told us both were healing, however we were not able to ascertain the full and accurate information about the person's pressure ulcers from the care records. We could not be assured that the service was fully assessing, monitoring and mitigating the risks associated with pressure care needs, because the information required was not recorded in people's care plans. Furthermore, there was a lack of monitoring of records so the gaps had not been identified.

The risks we identified for other people such as those associated with seizures, falls and infections for some people were not adequately assessed, mitigated and planned for with guidance for staff.
Information gained from healthcare professionals was not always used to update people's records appropriately. In the records for one person, we saw that they were at risk of epileptic seizures. Guidance about how to support the person with seizures had been given by healthcare professionals in the form of a letter. However, this had not been translated into appropriate care planning and risk assessment for this person. We also found that advice from the dietician was not always included in a care plan and risk assessment. There was not a system in place which had identified these gaps.

We were not able to fully ascertain whether there were enough staff deployed effectively throughout the home. Several people within the home had regular one to one staffing, and for some people, their care records did not accurately reflect what one to one support they required. For one person, their care plan stated that they received ten hours of one to one support during the day. However this one to one was not reflected on the dependency tool used for calculating staffing levels.

Care plans were not always consistent, with some plans lacking individualised detail and guidance, There was no effective system in place for checking the quality and content of the care plans. It had not been identified that the MCA had not been adhered to when planning people's care in order to ensure their rights

were upheld. It had not been identified that some care plans contained inaccurate, generic or out of date information. We concluded that there were not always accurate contemporaneous records kept in respect of each person living in the home. The care records were kept in different places and the relevant information was not always easily accessible

The registered manager also carried out regular checks during the day of the home and this included monitoring staff's interaction with people. We saw that these had identified some areas for discussion with staff, and these audits also checked the safety of the environment. However, these checks had not identified issues that were picked up during the inspection, such as staff boundaries with one person.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not have good knowledge of whistleblowing and how to report concerns. This meant we could not be assured that they would identify any issues and feel confident to raise them, or know who to raise them to.

We were concerned about the registered manager's lack of transparency. For example, the registered manager told us that they had not yet had the CCTV within the home up and running for the communal areas, and that they would go through the required processes when they decided to commence using it. However, we saw that the CCTV was operational on two screens showing two separate communal areas in the home in the morning, which by later on during the afternoon of the inspection had been turned off. A staff member also confirmed that these CCTVs had been and were at the time, in use in communal areas.

There were some quality assurance processes in place, including audits of infection control which identified any areas for improvement. The registered manager had also implemented processes to gain feedback from staff about their colleagues, which helped give them oversight of where some staff members may need to improve. They used this to support discussion in supervisions and monitor staff. We saw that medicines audits had picked up any gaps in recording and actions had been taken to discuss any discrepancies with staff. There was also an audit of people's healthcare appointments so that the registered manager could oversee that none were missed or were rescheduled if needed.

The registered manager had asked people living in the home for feedback as well as visitors such as the hairdresser, and family members. We saw that most of the feedback received was positive about the home. We also noted that two people's families had written to the home recently acknowledging the good care and support their relatives were receiving.

The registered manager was well known in the home to both residents and family and appeared to know residents and their close families well. Staff told us they also had regular contact with the registered manager.

Staff we spoke with said they had staff meetings every month where they were informed of any changes and discussed any important information. The staff team reported that they had a positive staff team and worked well together. They had a good morale and we observed staff working well together.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC of authorised DoLS and two serious injuries

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care according to their individual needs and preferences and care plans were not always thorough and up to date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Best interests decisions were not made in line with legislation. Mental capacity assessments were not completed when needed so the provider was not able to ensure consent was obtained and people's rights were upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always assessed, mitigated and planned for.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance The quality assurance systems in place were not effective at identifying areas where improvements were needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not adequately deployed to meet people's needs and provide person centred care. The staff had not received adequate training.