Thomas Owen Care Limited

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

Summary of findings

Overall summary

The inspection took place on 11 February 2016 and was unannounced. The service was last inspected during January 2015, at which time we found that there was a breach of Regulation 13 management of medicines of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that the service had not made the necessary improvements to meet this regulation.

Thomas Owen House provides nursing care and support for up to 39 adults with mental health needs and/or a physical disability. There were 34 people living at the home at the time of the inspection. Accommodation is provided mainly in single rooms with one double occupancy room. There are a variety of communal areas, including a dining area and several lounges, a hairdressing room, a kitchen, a laundry and bathrooms. There is also access to gardens and paved areas.

The home had a registered manager. 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 at the home, and staff had a good understanding of how to safeguard people from harm.

There were risk assessments in place for identified and perceived risks. Some risk assessments were good, however they were not always effective as the information used to create them was incorrect.

There were personal emergency evacuation plans in place for everyone who lived at the home, and the safety checks were in place and current.

There were enough staff to meet people's needs safely. There were some concerns about the pre-employment checks which had been carried out for some staff. This was a breach of regulation 19 (2) (a) fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. This was a breach at our last inspection and the provider had not made all the necessary improvements to meet the regulation. This was a breach of Regulation 12 (2) (g) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had undertaken a full induction and were regularly refreshed on their training. There was a wide range of additional training available which staff were accessing.

Staff were not receiving regular supervision or appraisals. Some staff had not received any supervision during 2015 or 2016. This was a breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

There were appropriate Deprivation of Liberty Safeguards in place; however the mental capacity assessments which had been carried out were inconsistent and incomplete in some cases.

The registered provider had not sought or gained consent from people who lived at the home for personal care, this had not been sought on their behalf and we did not see best interest decisions to show they were unable to give their consent.

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

People enjoyed the food they were served and told us they had plenty to eat and drink.

Most of the staff interactions we saw were kind and caring, although there were some staff who were detached and did not interact with the people they were supporting.

People's bedrooms were nicely decorated and personalised with their own belongings.

Some of the people who lived at the home were not supported with their grooming needs, with unclean hair, holes in their clothing and food stains on their clothing.

Care plans were in some cases detailed and comprehensive; however this was not consistently the case. The care files were disorganised and information was difficult to find. Reviews were not comprehensive and did not demonstrate evolving care plans.

People were offered choices where possible. There were activities taking place though these tended to be spontaneous and only offered to people who were in the immediate vicinity.

There was a positive culture amongst staff. We found that the registered manager was aware of the areas of the service which required improvement, and had made some progress on making improvements. However we found that the processes which were in place for monitoring the quality and safety of the service were not effective.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff had undertaken safeguarding training and demonstrated a good understanding of their responsibilities to safeguard vulnerable adults.

Pre-employment recruitment checks were not always carried out adequately.

Medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental Capacity assessments were not always carried out appropriately.

Staff were well trained and skilled to carry out their roles.

Consent to care had not been gained

Is the service caring?

Requires Improvement

The service was not always caring

though we saw some attentive and caring interactions some staff were disengaged and did not interact with people they were supporting.

Some people were not supported with their grooming needs

There was some evidence of institutionalised behaviour from staff particularly relating to cigarettes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were disorganised and inconsistent.

Care plans were not usefully reviewed and were not evolving with people's changing needs.

People were given choice where possible.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were processes in place to look at aspects of the service, and they were identifying issues, however these issues were not being rectified.

The service was seeking feedback from staff and relatives, but not from people who lived at the home.

There was inconsistency in the level of care dependent on which staff were working at the time.

Thomas Owen House

Detailed findings

Background to this inspection

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

This inspection took place on 11 February 2016 and was unannounced. The inspection was carried out by two adult social care inspectors and a specialist advisor, who worked in mental health services.
Prior to our inspection we reviewed the information we held about the service and notifications we had received from them. We gathered feedback from the local authority and other agencies who worked with the home including the infection control team and environmental health department.

As part of our inspection we spoke with eight people who used the service, nine support staff including the cook and the domestic staff on duty, a nurse, one of the deputy managers, the registered manager and the operations manager. We observed interactions throughout the inspection between support staff and the people who used the service.

We looked at the care records for 11 people who used the service, staff files and training records for three members of staff, medication records for everyone who used the service and various records relating to the safety of the service. These included complaints, incidents and regular auditing which was in place to monitor the quality of the service

Requires Improvement

Is the service safe?

Our findings

One person who used the service told us "I do feel safe here; I have been to much worse places." Another person told us "I am safe yes."

We spoke with staff about their understanding of their safeguarding responsibilities. One care worker we spoke with demonstrated a good understanding of protecting vulnerable adults. They told us what signs of abuse they would look for and knew which external agencies they could contact. They told us they knew how to contact the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the manager knowing they would be taken seriously.

People's care plans included risk assessments for both actual and perceived risk. They identified areas of risk dependent on the individual and included issues such as skin integrity, mobility, falls and health needs. The home used recognised assessment tools for looking at areas such as nutrition and tissue integrity.

Generic risk assessments were completed for fire safety and mobility. For instance people had a personal emergency evacuation plan (PEEP). Each PEEP was tailored to people's individual needs. For example we saw where people could undertake the evacuation unaided they had considered that the person may need help to combat their anxieties.

We saw where risks had been found, risk reduction strategies had been identified. For instance one person had experienced choking on food. A risk assessment had been put in place and was then further improved following a visit from a speech and language therapist (SALT). We saw the professional advice given had been incorporated into the person's care plan and during our inspection we saw the plan being followed.

The foundations of good risk management were in place; however we found the process to be significantly compromised due to conflicting recording of people's needs and abilities. For example, one person had a falls assessment which recorded they needed spectacles, however from reviewing the rest of their care records we noted they were also hard of hearing which had not been recorded as a risk factor, when it should have been. However their PEEP assessment recorded partial hearing loss. Another person's nutritional assessment record showed the person was of normal build whilst other records showed the person to be obese or overweight. The person also had a tissue viability assessment which recorded they had full mobility yet another document recorded an operation had left the person with residual weakness and loss of sensation. Their falls risk assessment recorded they had a hesitant gait. This conflicting information meant care staff were potentially unable to deliver consistent and safe care to vulnerable people.

The outcome of risk assessments gave misleading information regarding people's overall dependency. For example the outcome of some falls and nutritional risk assessments came to a conclusion of 'no cause for concern'. When the correct information, such as recording people were obese, was fed into the assessment the conclusion would have been 'cause for concern'.

The registered manager told us that there were eight care staff and a nurse on duty throughout the day with a period of two hours between 13:30 and 15:30 where there were both staff from the early and late shifts on together. We reviewed the staff rotas for a period of four weeks and 13 shifts where there were only seven staff on duty. There were three occasions where there was an additional staff member on duty. The registered manager told us that there were always two care staff and a nurse on duty at night; however this was not clear from the rotas we reviewed. We discussed this with the operations manager who said that there had never been less staff than that number of staff on duty at night.

There were three people who used the service who required a member of staff to be with them at all times when they were awake. This meant that three of the eight staff were always occupied with one person each. During handover we noted that it was discussed that one of the people who needed one to one supervision had been awake throughout the night. We were concerned that there was no provision for one to one care should it be needed at night. We discussed this with the registered manager who assured us this had not been a problem. We felt that there were sufficient staff to support people safely, under normal circumstances.

We reviewed the processes which were in place for staff recruitment. We looked at the recruitment files for three staff. We found that whilst there was evidence of an application, interview and offer of employment, we had some concerns about the checks which had been carried out in two of the three files we looked at. This was because in one case the member of staff had left and had some time later re-applied and been re-employed. There had not been a new disclosure and barring service (DBS) check carried out. There was a criminal records and barring service check dated 2007. There was a reference which had been gained in 2014; the other reference on their file was from 2007. We were concerned references had not been checked properly as we could not see any evidence the references had been verified and in one case there had been no attempt to contact the person's last employer and no reason recorded why this was. This meant that the registered provider was not making all necessary checks to ensure that staff were suitable to work with vulnerable adults.

This is a breach of Regulation 19 (2) (a) fit and proper persons employed of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

Medicines were administered to people by trained nursing staff; however our observations found their practice fell short of an acceptable standard. We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to try and ensure they complied with current legislation, however some features were absent. For example there was no guidance for staff regarding what action to take when people were asleep when medicines were due for administration. We witnessed a number of occasions when people were not administered their medicines due to being asleep. This meant that if a person was asleep they did not receive their prescribed medicines.

Our inspection identified some features of the provider's current policy were not being met by nursing staff. During the morning we observed a nurse administering medicines. We asked the staff nurse about the safe handling of medicines to ensure people received the correct medication. Answers given along with our observations demonstrated medicines were not consistently administered in a competent manner. For example, on three occasions we witnessed people being administered Lansoprazole; the label on the medicine gave clear instruction it had to be administered 30 to 60 minutes before food yet on all occasions it was administered after food. We also witnessed the administration of insulin almost an hour after breakfast whilst the instruction was to administer half an hour before food.

The nurse told us it was difficult to administer some medicines due to people being asleep yet the provider's

policy provided no guidance. The National Institute for Health and Care Excellence (NICE) document "Managing medicines in care homes guideline (March 2014)" indicates providers should consider in a medicines administration process guidance on administration of medicines if the resident is asleep.

We saw one person was prescribed an antipsychotic medicine by depot injection. The person had been prescribed another medicine to counter the side effects of the antipsychotic medicine. The medicine administration record (MAR) recorded the medicine had not been administered in a morning on seven occasions and a further six occasions when the medicine was refused over a period of 17 days. The afternoon administration was never recorded as being given and the evening administration recorded only 13 refusals. On no occasion did we see nursing staff had detailed the circumstances and reasons for the recorded refusal. This meant that the person was not receiving their medicines in line with the prescriber's instructions and there had been no action taken to address their refusal to take their medicine.

We also witnessed medicines which were prescribed to be administered twice a day being treated on a PRN basis. Later discussion with the manager assured us they would raise the matter with the prescribing GP to review the situation.

The Nursing and Midwifery Council (NMC) Standards for Medicines Management (2010) sets out a number of standards for registered nurses. Standard 8 (administration) states that: 'as a registrant, in exercising your professional accountability in the best interests of your patients: you must make a clear, accurate and immediate record of all medicine administered'. During our inspection we saw the nurse signing for medicines which they had administered on previous days but forgotten to sign for.

We saw the outcome of a recent medicines audit had identified the need to record the quantities of boxed medicines after each administration. The MAR sheets included a record sheet for each boxed medicine yet observations showed the completion of this record was not consistent.

We saw allergies and intolerances to medicines were recorded on the medicines administration record. This helped to ensure that staff were aware of medicines which were likely to cause harm to people and would know not to give them.

The provider's current guidance on PRN administration was not adequate and was not being followed. The policy stated that PRN instructions which stated the medicines were to be administered 'as required' are unacceptable. However we noted on a number of occasions ambiguous instructions were being used. For example, one person was prescribed a medicine 'as required' up to three times a day. There was no instruction as to the time delay between each dose or any guidance to enable staff to judge the need for, or the effect, of the medicine.

We looked at MAR sheets and care records to ascertain how frequently PRN antipsychotic medicines were being used to control behaviour that challenges others. In discussion with nursing staff and scrutiny of the MAR sheets we were assured that other interventions were the preferred option. This demonstrated that the registered provider was not using medicines to subdue people and were using less restrictive methods to manage their behaviour.

We carried out an audit of a sample of eight medicines dispensed in boxes or bottles. We found all medicines to be accurately accounted for. Some medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. Whilst we found no controlled medicines in use appropriate storage facilities existed. The treatment room was locked when not in use.

We saw creams and liquid preparations were dated when they were opened and none had exceeded their expiry dates. The application of creams was recorded on separate topical medicine administration sheets in people's bedrooms. We looked at two sheets which indicated the cream was being applied as prescribed. We saw prescribed food supplements were administered in accordance with the MAR sheet.

Drug refrigerator and medicine room temperatures were checked and recorded to ensure that medicines were being stored at the recommended temperatures. However we found some medicines were incorrectly stored. We found a pen containing insulin in the fridge. The instructions on the box stated "once opened do not refrigerate". We brought this to the attention of the registered manager who said they would ensure the medicine was correctly stored in future.
This meant that the registered provider had not made the required improvements to meet this regulation since our last inspection.

During handover; the registered manager instructed staff to complete a recording form for applying creams. After handover we asked two members of staff to show us these recording forms for the people they were supporting. One related to a service user being treated by a specialist tissue viability nurse which could not be located; and the other was only completed three out of the four days it had been running.

These examples demonstrate a breach of Regulation 12 (2) (G) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked around the communal areas and looked in some people's bedrooms. We found the service was clean and was, with the exception of the sluice and surrounding area, free of unpleasant odours. We saw that the provider had instituted a recognised system of colour coding cleaning cloth, mops and buckets. We observed areas of the home being cleaned with the correct cloths. We spoke with the cleaner who demonstrated their understanding of the need to maintain separation of cleaning equipment. We saw staff used gloves to deliver personal care and we witnessed staff regularly washing their hands. We found the home provided an adequate supply of gloves, anti-bacterial soaps and gels which were placed in strategic locations.

We completed a tour of the premises as part of our inspection. The home is constructed on two levels. We inspected six bedrooms, the kitchen, laundry and various communal living spaces. All radiators in the home were covered, or a cool panel design, to protect vulnerable people from the risk of injury.

We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found the fire escapes were clear of obstructions. We found floor coverings were appropriate to the purpose of the rooms. Floor coverings were of good quality and with one exception were properly fitted; however there was one area with an ill-fitted carpet which did pose a trip hazard. This was highlighted with the registered manager.

We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant and within date. We saw Control of Substances Hazardous to Health Regulations 2002 (COSHH) assessments had taken place to prevent or control exposure to hazardous substances. All cleaning materials and disinfectants were kept in a locked room out of the reach.

Door alarms were fitted on the majority of the bedrooms and staff we spoke with told us "We all carry radios or pagers so we can answer when the buzzer goes off". When we asked to see one, the said staff member replied "I haven't got mine because I came out of handover in a hurry". We asked three other care staff to see their radio or pager on the way back to the office however no-one had one with them. This meant that staff

were not aware when alarms were going off as they did not carry the equipment which alerted them to this. There were however displays of and audible alarms placed around the building to alert staff.

Incidents and accidents were recorded and analysed monthly to determine the number of each type of incident/accident and these were subject to further analysis. We found clear descriptions of preventative action which had been put in place following incidents. As a result of the audits and analysis we found accident and incident rates had reduced over the past year with no evidence repeat incidents.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us "The staff know what they are doing, they are generally very good." Another person told us, "The food is very good, I enjoy what they give me and there is always plenty to eat and drink."

We spoke to staff about the training and induction they had received. Staff told us that they had undertaken a full induction and they had been able to shadow more experienced staff before they were expected to support people on their own. We looked at the training records for staff and saw that staff were regularly accessing refresher training on important subjects including moving and handling and safeguarding. Staff told us that they felt that they had the skills and knowledge they needed to support people who lived at the home.

We saw from staff files that staff had been offered and had undertaken a variety of additional training which included depression awareness, bi-polar and schizophrenia awareness, dementia and cognition and dignity in care. This meant that the registered provider was investing in ensuring that the staff they employed were knowledgeable and skilled.

We reviewed the records for how often staff working at the home received supervision sessions. We found that this was sporadic and inconsistent; records showed that some care staff had not received any supervision in 2015 or 2016. The supervision recording form used was designed by the registered manager and gave feedback based on the CQC key lines of enquiry; however there was no section to record the supervisee's own issues or agreements on improvement goals. There was a generic supervision agreement in the files we looked at but this had not been amended to show the frequency of supervisions which were required or to record individual goals.

We found that only one registered nurse had received supervision in 2016 with the other registered nurses last receiving supervisions in September 2015. The registered manager told us when we asked them about this "I know we have fallen behind with the supervisions but we are working on improving them." We asked the registered manager whether there had been any appraisals carried out; they confirmed that there had been very few. The registered manager told us and staff confirmed that they regularly fed back to staff on their practice and gave them guidance; this was not documented so we were unable to evidence that this was taking place. This meant that the registered manager was not providing adequate support to their staff to allow them to learn and develop.

This was a breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We attended the handover meeting which took place in the early afternoon. We observed that this included the staff who were coming on to duty and the nurse who had been on duty during the previous shift. The nurse outlined the information for each person who used the service in turn, however most people were just reported to be 'fine'. The registered manager allocated some specific duties to some of the care staff for

example to remind a person about an upcoming event to try to gain their interest and enthusiasm.

The registered manager produced a quarterly newsletter, which shared news of activities with pictures of events which had taken place, for instance a trip to Old Trafford. This newsletter was intended for the families and friends of people who lived at the home. This meant that the relatives of people who used the service were able to see what their relatives had been doing throughout the year.

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

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

We looked at the mental capacity assessments (MCAs) which were in place in people's care files; we found they varied in both consistency and quality. There was no evidence of service user involvement during the process and MCAs were not always signed or dated. There was no name or designation of the person conducting the assessment to indicate their qualification to carry out the assessment. Deprivation of liberty safeguards (DoLS) applications had been authorised or were in the process of being reviewed for all except two people who lived at the home. This was because two people had been assessed as having the capacity to make their own decisions. We found that whilst the legal requirements for DoLS had been met the quality of the initial assessment may lead to unnecessary referrals to the court of protection. This was because there may be challenges about the validity of the mental capacity assessments which had led to a DoLS being applied for.

We asked the registered manager if any of the people living at the service were subject to a Do Not Attempt Cardio Pulmonary Resuscitation order (DNACPR). We were informed by the registered manager that two people had DNACPR documents in place. We asked to see the documentation and found that there was only one in place. We were informed by the operations manager that the second DNACPR had been "Refused by the GP". this posed the risk that staff believing that a person was subject to a DNACPR when they were in fact not may have led to a delay in treatment to the person this related to; if they suddenly deteriorated. The registered manager told us they would ensure that all staff were aware that the person did not have a DNACPR.

We looked at 11 people's care records to review whether the registered provider had sought and gained consent to provide care and support to the people who used the service. In cases where people have been assessed not to have the capacity to give their consent records should demonstrate this and that accordingly a best interest decision has been made. We found that there was no evidence that consent to care had been gained in the files we reviewed, and we did not see that capacity assessments or best interest decisions had been carried out appropriately. In one care file we reviewed we found that there was a form for a mental capacity assessment to give consent to care dated 9 February 2016. This form was incomplete and there was no name of the person who had carried out the assessment. There was no decision recorded as to the person's capacity to give their consent. We discussed this with the registered manager who told us the person who completed must have got 'called away' which was why it was not complete.

This was a breach of Regulation 11 (1) Need for consent of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

We observed the lunch service as part of our inspection. Staff set the tables in preparation for the meal, with table cloths and cutlery. There were no condiments available for people to use. We saw that most people came into the main dining area to eat together. Staff told us that people who needed assistance to eat were served first so that staff had time to assist them without rushing. We saw that this was the case. There was also a person who was agitated who was served before everyone else.

We saw that there was a menu written on a board in the dining area. This was a task undertaken by one of the people who used the service. There was a choice of two main meals available. People were asked what meal they would like by staff; however there was a significant delay of 25 minutes from the first table of people being asked what they wanted and them receiving their meals. There were further delays on service to the other tables; however the food which was served was hot when it reached the dining area.

We saw one person was given a bowl of plain mashed potato for their lunch, we did not see staff ask them what they would like. We asked the registered manager about this and they told us that the person would only eat very plain food, but agreed they should have been offered the same menu choices as other people.

People told us the meals were 'nice' and they liked the food they were given. Three people we spoke with confirmed that if they did not want the choices on the board they would be offered an alternative, although we did not see this during inspection as everybody ate the choices which were available.

We noted that people had access to a range of drinks at all times as there was a vending machine which was free for the use of people who lived at the home. We saw that people used this throughout the day. People were offered a good range of drinks with their meals, which included milk for a person with diabetes who was unable to drink juice. We spoke with the cook who demonstrated a good understanding of the specific needs of the people who used the service. There were documents displayed which showed dietary needs for various people and how they needed to be met. The cook was able to explain to us how they would fortify a person's diet if they were at nutritional risk.

We saw evidence in written records we reviewed of staff working with various agencies and ensuring people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, community psychiatric nurses, speech and language therapists, dieticians and dentists.

Requires Improvement

Is the service caring?

Our findings

One of the people who lived at the home told us "The staff are lovely, they are really nice." Another person told us "I sit here all day, I like to chat to people if they will come to talk to me, but they don't often come."

We observed staff in their roles throughout the day which covered both the day and evening shifts. We found staff were kind, caring and compassionate in their interactions with people. We asked people if they liked living at the home and they told us that they did. One person said, "Yes it's OK here." During the course of the day we noticed a distinction between the staff team who were on duty in the morning and the staff team on duty in the afternoon. We observed there was a much higher level of interaction and motivation which created a warm atmosphere during the afternoon. Some of the staff we observed in the morning were detached and unresponsive to the needs of some of the people who asked for assistance. For example we saw several occasions where people were ignored by staff, these people then approached other people with the same requests until they gained a response. This was reported to their registered manager who said they would speak to the staff concerned.

We observed that some of the staff who were delivering one-to-one care appeared to be detached from the person they were supervising and there was very little interaction or encouragement taking place. We observed on a number of occasions staff leaning against the wall in one of the lounges and this gave the impression of observing people rather than interacting and directly caring for them. We noted at lunchtime that there was a member of staff leaning against the wall in the dining room looking at the ceiling. A person approached them asking for a cigarette. The member of staff did not speak, and instead pointed at the clock. This demonstrated that there was institutionalised behaviour in the home as people were being restricted to 'smoking times'.

We discussed the issue of people having access to their cigarettes with the manager who told us that staff would not stop people from accessing them, but they would try to guide people to make good choices. They explained that the conditions some people had meant that they would smoke all their cigarettes in a short time frame. The registered manager told us that there was no timing involved in when people could smoke. However throughout the day we observed staff referring people to the time and telling them it 'wasn't time yet'. We discussed this again with the registered manager as this was institutionalised behaviour. The registered manager said they would address this with staff. We looked at the people who we had observed as being restricted and found that there were mental capacity assessments in place which showed that they did not have capacity to make some decisions; however these were not specific to them smoking.

We looked at the care planning relating to one to one care for one of the people we observed being supervised. The care plan stated that their one to one care 'should include meaningful activities'. We observed a person who required one to one supervision wandering around the dining area with very little interaction from staff. This person had no laces in their shoes, we asked the registered manager why they had no laces and they could not offer an explanation for this. These examples demonstrated that the registered provider was not monitoring the quality of the care and support which was being given to people

who required one to one support.

We looked at six people's bedrooms. Five bedrooms were single rooms with private toilets and showers which gave people privacy. One large bedroom we visited was for two people divided by a curtain. Each half of the room was separately decorated with ample space for people to create their own space. We asked the registered manager about the arrangements for these people to share a room. They explained that this was their choice and this arrangement had been in place for a long time. We saw rooms were personalised with people's own possessions, photographs and personal mementos. We felt that whilst this situation was not ideal the people concerned had the capacity to choose to share a room and they were happy with the arrangements which were in place.

From care records we saw the service had worked with relatives to create life histories to help staff to understand the choices people would have previously made about their daily lives. Discussion with the registered manager and members of care staff indicated people's past personal histories were well known. This was particularly important as some people had a diagnosis of dementia, psychotic illness or other impairments which affected their ability to make daily decisions and be involved in their care.

We saw from one of the care files we reviewed that the person had access to and independent advocate or family member who acted on their behalf. An advocate is a person who is able to speak on other people's behalf when they may not be able to do so, or may need assistance in doing so, for themselves.

We saw that confidential information was stored in offices which were locked when they were not occupied. Staff made sure that they did not discuss people in communal areas where they may be overheard by people who used the service or visitors to the home. This meant that the service was maintaining and respecting people's confidentiality.

We observed that some of the people who lived at the home were not being adequate supported with their grooming needs. This included wearing clothes with holes in them, food stains and unkempt hair. We discussed this with the registered manager who was not able to offer explanation other than one person was reluctant to spend money on new clothes. We saw during the morning that one person was wearing trousers which were too big for them; they had slipped down exposing their body. Staff had not noticed this. When we notified staff they did take action and the person returned wearing a pair of braces to keep their trousers up.

Some people had chosen to keep their rooms locked. They kept a key accessed their room as they wished. We saw that bedroom doors were kept closed when people were not in their rooms. This meant that people's rooms were secure and people were in control of who accessed their rooms.

We did observe some occasions when staff encouraged people to be independent. For instance there was a person who was sometimes able to manage to feed themselves with a knife and fork and they were encouraged to try. There was also a person who had slumped in their wheelchair; staff encouraged them to push themselves up using the arms of the wheelchair. They were not able to do this as the arms were too high. A member of staff held the dining table they were sat at steady so they could use that to push themselves up.

In one care file we reviewed we found an entry written by the registered manager authorising the person to gift their personal possessions to a member of staff. This was in breach of the organisations own policy on gifts . We discussed this matter with the registered manager who told us they had agreed to the gift as the property was being disposed of whether it was given to the member of staff or not, we expressed our

concern that there should be no exceptions to the rules as stated in their own policy.

Requires Improvement

Is the service responsive?

Our findings

A person we spoke with told us "I don't know anything about my care plans." One person said, "I like Country and Western music and western films, nobody else here does so I don't get to do what I want. The radio is always on; I don't like this kind of music."

We looked at the care plans for 11 people who lived at the home. We found that there were three different styles of care plans in use. Some of the care plans were generated by a computer programme which asked a series of questions to create the documents. The registered manager told us that they were removing this type as they felt that they were generic and not person centred. There were also two variations of the newer type. Some care plans had a separate document for each aspect of care, whilst others considered various aspects of related care in one document. We saw no evidence that there had been any consideration of the views of the person to whom the care plan referred to or of collaboration with family members. Some of the care plans had large amounts of information added to the end and in columns at the side instead of a new plan being written. This was difficult to follow and confusing to read.

We found that whilst some of the care plans were detailed and would give care staff all the information they needed to support the person, they were not consistently so. There was conflicting information in the care files in different sections. For example in one care plan a person was described as 'fully mobile' in one section and detailed to have poor mobility and needing a wheelchair for all but very short distances in another.

We saw in the files we reviewed that there were no pre-admission assessments. We found that some of the assessments which had been used to inform care planning were not correct as the wrong information had been used to create them. We found that risk assessments referred us to care plans which did not identify the risks and put in measures which would reduce them. Care plans were not always person centred and did not always reflect people's preferences, likes and dislikes.

We found that the care files were disorganised. There was an index which showed where sections of various documents should be filed. We found that this process was not followed which made information difficult to find. There were loose documents in the front of some of the files. We asked the registered manager about this and they said they 'should be filed'.

We looked at the review process for care plans and found that in most cases there was a simple phrase such as 'remains valid'. We saw in two cases that there had been a change required and this had been identified but not carried out. The next few months would then record 'remains valid' despite the care plan not being amended or re-written. In one case this had been identified for the second time and the care plan had still not been changed. This meant that the registered provider was not ensuring that care plans were in place which met people's needs and were regularly reviewed and amended and there was no evidence that care plans were evolving in line with people's changed needs.

The registered manager told us that they no longer employed an activities person, as they felt that this had

not worked well. They told us that they expected all staff to be involved in the provision of activities and that this was led by the nurse in charge. During the inspection we observed people sitting around asleep or staring for long periods of time both in the dining room and the lounges. Some people were displaying repetitive behaviour for example asking for a cigarette. Staff told them it was not time yet, or pointed to the clock. Staff did not distract these people by occupying them with meaningful activities.

We noted that there were no activities taking place in the morning, however in the afternoon we saw some members of staff playing board games with a small number of people and other people were engaged in knitting. There was an entertainer booked to attend the service in the evening.

There were some people who did not tend to sit in the rooms where most other people and staff were. The activities we saw all took place in the dining room and the main lounge. People who sat in other areas were not included. We discussed this with the registered manager who agreed that some people were at risk of being isolated, and said they would raise this with staff and would ensure that people who chose to sit in other areas were included in the activities.

We saw that where possible people were offered choices. Sometimes these choices were not as extensive as they could have been. For instance, staff asked people what meal they would like, they did not ask whether they wanted all the vegetables or whether they may want gravy.

It was clear that people who lived at the home were individuals and were treated as such. Staff addressed people as they preferred and chatted to them about things which were relevant to them.

We reviewed the complaints and concerns records for the service. We saw that there had been five complaints recorded since the last inspection. We saw that there had been investigations carried out for each complaint and that there was a letter sent to the complainant in line with the company policy and timescales. We saw that there was evidence of analysis of the complaints, which was in the format of a timeline and there were lessons learnt identified from them.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the home.

There was a positive culture amongst the staff at the home and staff we spoke with felt supported in their duties. They received a handover at the start of their shift and felt they could approach the management team at any time. One care worker said "I feel equipped to do my job, the manager is a great mentor and every resident is looked after in a way that's individual. I'm really happy working here, it's made me want to go and train to become a nurse."

We found there were systems in place to assess, monitor and review the quality of service provided. We looked at the results of a medicines audit which had identified shortfalls in the administration and management of medicines. We asked the manager about their findings and actions to remedy the shortfalls. We found the manager had introduced a system for staff to check and record stocks of boxed medicines and had followed this up with an audit of the outcome of the new process. However we found during our scrutiny of the MAR sheets that the required checks were not being consistently carried out. The manager assured us the system would be reinforced to trained nursing staff.

There were processes in place to audit the complaints and accidents and incidents which occurred in the home, and there was evidence that there was analysis and lessons learnt being drawn from these audits. There was a process which the registered manager told us they had recently implemented to audit care plans. We looked at the evidence from the recent audits and found that the process was still 'tick box' although the registered manager had written suggestions for improvements to be made on the audits. Some of the labelling of the columns on the forms was unclear. There was no process for ensuring that the actions which had been identified were completed.

The staff team was variable, with a very different feel to the home in the morning and the afternoon. The afternoon staff were much more involved with people and their enthusiasm was evident, whereas earlier in the day we had seen staff to be disengaged. This meant that the standards of care were not consistent dependent on who was on duty, and that the senior staff had not identified this issue and taken action to address it. We discussed this with the registered manager who said they were disappointed with our observations and that they would speak to the staff concerned.

There was a nurse on duty who the registered manager told us was responsible for leading the other staff. We did not observe that this was the case; however the registered manager told us this may be in part because the nurse on duty was new in post. We did not see any direction being given to the staff team during their shifts, other than some basic instructions to some staff during handover. Although the registered manager informed us that the daily tasks were allocated throughout the day, it was less apparent to the staff on duty. We saw that one to one observations were passed over to the next member of staff when the staff member needed to go somewhere else with no handover between staff of the person's current mental state.

The registered manager understood the requirements of their registration, and notified us (CQC) of events which had taken place in line with regulations.

We looked at the daily care records for the service which were recorded electronically. Each member of staff had a log in and could record interactions and interventions via an electronic tablet. This was stored centrally and gave a timeline of what had happened to each person throughout the day. This meant that there were notes created throughout the day which were timed and stored in order on the computer system to make them easily accessible.

The registered manager told us that they regularly observed staff practice and fed back to them about this. These interactions had not been recorded and could therefore not be evidenced.

The registered manager and the operations manager were open with us throughout the inspection and had identified areas which needed improvement. The registered manager provided us with a document they had created since coming into post which showed the improvements they had made, which included the introduction of the vending machine to allow people to access their choice of drinks independently, gaining a 'gold star' healthy choices award for demonstrating healthy balanced diets were provided and the introduction of the quarterly newsletter.

The registered manager accepted that some of the areas of concern we identified were directly attributable to them prioritising other areas of the service, which had meant that other areas had lapsed for example the lack of staff supervision and appraisal. We discussed with the registered manager that they needed to be able to maintain all aspects of the service to the required level.

This was a breach of Regulation 17 (1) Good governance of the Health and Social Care Act (Regulated Activities) Regulations 2014 as the registered manager had not ensured that all aspects of the service were compliant and did not have systems in place which allowed them to effectively monitor the quality and safety of the service.

There was evidence that the registered manager had sought feedback from staff and relatives of people who lived at the home. We did not see any evidence that feedback had been sought from the people who lived at the home in the same way as from staff and relatives however there were meetings at which some feedback was gained in relation to activities and suggestions for the menus.. The surveys we saw had been analysed to some degree but we did not see any action plans which had been created to use the information gained to inform future improvements. This meant that whilst there was feedback being sought, this was not from the people who lived at the home, whose feedback was the most important and relevant.

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 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 Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed lack of adequate pre-employment checks for care staff

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was no evidence that staff were being appraised and there was evidence that staff were not receiving regular supervision and support

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	no evidence that consent was being sought or gained - poor level of compliance with the MCA 2005 in relation to MCA's

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were still not being managed safely this is a continued breach from last inspection January 15

The enforcement action we took:

Warning notice issues

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	lack of leadership, very few supervisions, no appraisals, poor auditing in some areas, inconsistent staff attitudes lack of policy and procedures around meds

The enforcement action we took:

Warning notice issued