Amson Care Ltd

Shiels Court Care Home

Inspection report

4 Braydeston Avenue
Brundall
Norwich
Norfolk
NR13 5JX

Tel: 01603 712029

Date of inspection visit: 16, 22 and 24 December 2015
Date of publication: 05/02/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 16, 22 and 24 December 2015 and was unannounced.

Shiels Court Care Home is a residential home providing accommodation and care for up to 43 older people, many of whom are living with dementia. At the time of this inspection 37 people were living in the home.

The registered manager had left the service in November 2015. 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. The then deputy manager had taken on the manager's role and was leading the service with support from the provider two days a week. They are referred to as the manager throughout this report.

Summary of findings

At this inspection we found major shortfalls in many areas of the service and identified that people were at risk of harm. We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two breaches of the Care Quality Commission Registration Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

We found that there had been longstanding failures in identifying and notifying relevant authorities about safeguarding incidents. Incidents and accidents were not always recorded. When they were recorded the information from them had not been utilised to identify patterns in risks to people's welfare. This prevented the manager from understanding where the risks to people were in how the service operated.

Risks assessments provided little guidance for staff on how to support people safely and did not always cover the risks to people we identified during the inspection.

People's medicines were not always available and were not always administered in a timely manner to ensure that people would benefit from the relief they provided.

Insufficient staff numbers were deployed to meet people's needs throughout the home. In The Coach House, the home's unit for people requiring a high level of support, people were unaccompanied for significant periods of time, putting their welfare at risk. There were up to 15 people in the main lounges but very often staff were not available to meet the needs of the people there.

The manager and provider had a poor understanding of the Mental Capacity Act 2005 (MCA). The service was not acting in accordance with this legislation. This had led to decisions being made without people's consent.

The new manager had improved accessibility to staff training and a substantial training programme was underway. However, no staff had been trained in the MCA. Supervisions and appraisals needed to be fully implemented to ensure staff were able to support people effectively and safely.

People's nutritional and hydration needs were not being met. Staff did not understand the nutritional screening tool they were using and did not follow the related guidance when people were deemed as at risk. Food and fluid charts were not informative and actions were not taken to ensure people were supported with their nutrition by health professionals.

We observed both good and poor staff interactions with people living in the home. Staff were well meaning and caring, but some lacked insight into how their actions or comments could be perceived.

People's needs had not been identified and planned for. Several people had significant health conditions which were not reflected in their care plans. Risk assessments had been combined with care plans. There was little detail to show how risks were to be mitigated and the guidance for staff to follow was minimal. There was little for people to do during the day. Most people spent their days asleep, watching others or walking about the home.

The service was poorly managed. The quality management in the service was lacking in several areas and was not identifying issues when they arose. Notifiable events had not been reported to CQC for a considerable period of time.

The staff were supportive of the manager and provider and there was an open culture in the home which benefitted people living there and staff alike. The provider and manager had recognised that there were a lot of improvements that needed to be made, but until this inspection had not been aware of span of issues in the home that required addressing.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not

Summary of findings

improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Systems and processes in place to safeguard people from potential and actual abuse were not effective.

People were at risk of unsafe treatment because medicines were not managed in a safe way.

Individual risk assessments were not always in place where required and gave little detail about how to mitigate risks to people's welfare.

The service did not ensure that sufficient numbers of staff were deployed. People's dependency needs were not taken into account.

Inadequate

Is the service effective?
The service was not effective.

There was little understanding of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were not adequately supported with their nutrition and hydration needs.

The environment in The Coach House was not conducive to the needs of people living with dementia.

Inadequate

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

We received mixed views about whether staff treated people with consideration.

We observed poor practice when staff supported people who needed assistance with meals in the main dining room.

There were no arrangements to ensure that people or their relatives were involved in planning people's care.

Requires improvement

Is the service responsive?
The service was not responsive.

People did not receive care that met their individual needs and preferences.

People had confidence that complaints would be dealt with fairly and effectively.

Inadequate

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

Inadequate

Summary of findings

Statutory notifications were not being made as required to inform CQC about important events that occurred in the home.

The auditing and monitoring systems in place in the service did not identify where improvements needed to be made. The provider's monitoring of the home was not robust.

Shiels Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 22 December 2015. A pharmacist inspector carried out an inspection on the 24 December 2015. The inspection was unannounced.

The inspection team comprised of three inspectors and a pharmacist inspector on 24 December 2015.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service.

During this inspection we spoke with thirteen people living in the home, relatives of two people, a visiting GP, the manager, the provider and eight staff members.

We observed care and support being provided to people throughout the inspection.

We looked at the care plans of six people and medicines records for nine people as well as various records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

One person told us, "I feel safe here because the staff are good and always there when I need them." However, we found that safeguarding practices within the home did not make sure that people were protected. We reviewed documentation in The Coach House, which is a part of the home where people requiring a high level of support lived. Some of these people periodically presented behaviour that challenged others. We found that in a recent four week period there had been four incidents where people had hit other people. These had not been recorded as incidents.

The local authority told us that these incidents had not been reported to them. In failing to report these incidents to the local authority the service is not ensuring that the local authority can properly support and monitor people who may present a risk to others. Consequently, the service had also failed to benefit from the support that would be available from the local authority to help them minimise the risks to people's safety and help ensure people's welfare.

The service had a Protection of Vulnerable Adults policy. However, this did not have contact details for the local authority's safeguarding team or instructions for staff on who needed to be contacted or notified of events that took place.

Twenty-six staff had received safeguarding training in November 2015. Some staff we spoke with were not clear about the requirement to make safeguarding referrals or what the arrangements for this were in the home. One staff member told us they weren't sure what happened when incidents occurred, they weren't really discussed, but that the manager would put new risk assessments in place.

People were not protected from abuse because the provider did not have adequate systems in place to minimise or act upon safeguarding incidents when they occurred. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was poor identification and management of risks to individuals in the service. Risk assessments provided little detail for staff about how to manage people's risks.

One person living in The Coach House had been identified as at risk of ingesting substances and had previously ingested shaving foam. When we looked in their bathroom they had three shaving foam pumps and other toiletries in their cupboard. The communal toilet also held toiletries. At one point during our inspection the kitchen in The Coach House had not been locked. There was a tray of cleaning chemicals, including bleach and a tin of drink thickener on the counter. These substances would be hazardous to people's health if accidentally ingested. We advised the manager of our findings and they took immediate steps to secure substances in The Coach House.

One person had sustained a hip fracture in the summer. Upon return from hospital it had been recorded in a falls risk assessment that the person was unable to weight bear. Another part of the person's care record stated they were able to weight bear with two staff members. There were no instructions for staff on whether equipment was needed or what actions they needed to take to support the person to mobilise. The person spent time during the day lying semi-prone on a large bean bag in a lounge. The person had previously been identified as at risk of choking and this may not have been an appropriate position for them. The manager told us this had been put in place because the person was in danger of sliding off chairs. There was no reference to the risk of falling from chairs in their care plan and no professional guidance had been sought about how to reduce the risk. Therefore, the service could not demonstrate whether the action they took was an appropriate or safe response to the concern.

Staff were not always clear about when they would be expected to complete an accident or incident record. Accident and incident analysis was not taking place. This meant that it was difficult to identify whether changes could be made to help prevent future re-occurrences. For example, analysis of where incidents took place and what time of the day they occurred could help inform staffing arrangements. The numbers and types of incidents recorded for individuals could help identify when referrals to health professionals needed to made.

On 24th December 2015, our pharmacist inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

Medication records did not confirm that people were receiving their medicines as prescribed. When we compared medication records against quantities of medicines available for administration we found numerical

Is the service safe?

discrepancies and gaps in records of medicine administration that did not confirm that medicines had been administered as intended by prescribers. We also found that some medicines had not been administered because they had not been made available to administer or had not been obtained in time. This placed people's health and wellbeing at risk.

We observed that the morning medicine round was delayed so some people received their medicines later than scheduled and intended by the prescribers. In addition, records did not clearly show the times medicines had been either administered or were scheduled for administration. Medicines scheduled with multiple daily doses may not have been administered at appropriate intervals and medicines intended for administration early morning or at breakfast were not administered until later. During the morning medicine round there were two senior carers involved in medicine administration in the same area of the home which could have led to confusion and error.

We noted a large delivery of people's medicines that were stored in an open office unattended by staff. These medicines could have been accessed by people placing them at risk of harm. In addition, keys to the storage of medicines were not being held appropriately by staff. Containers of insulin for the management of diabetes were being stored in a refrigerator where the temperature was not being monitored or recorded. The carton in which the insulin was stored had become soaking wet within the refrigerator and so the insulin may have no longer have been suitable for use.

These concerns meant that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I get the help I need but sometimes I have to wait 10-15 minutes because staff are busy." Another person told us that they had been assisted to get up at 10am that morning, but they preferred to get up earlier. They shrugged and told us, "It happens sometimes. I know I am not the only pebble on the beach here." A third person told us, "A lot is put on the staff here."

Staff told us they needed more staff as they were unable to spend quality time talking with people generally and were focused on the next task they needed to carry out. Staff told us that seniors sometimes helped out 'on the floor' when they were not administering medicines to people or accompanying health professionals on their visits. They also told us that sometimes the manager needed to help out and that staff absence wasn't always covered. Staff told us that they were not always able to ensure people had baths. A staff member in the The Coach House told us that due to the high levels of need of people in this part of the home people did not always receive their medicines when they needed them.

At the time of this inspection 12 people were living in the Coach House and 25 people were living in the main part of the home. During our inspection we observed periods in excess of 30 minutes when people in The Coach House lounge were not supported by staff. When staff were not available to support people their needs were not being met. One person who was eating breakfast at the dining table had dribbled into their food and on to the table. Two people stood up and whilst walking around the lounge bumped in to each other and pushed each other. Another person who was unsteady on their feet wanted to get up but whilst trying to do so fell back on to the settee. A further person was seen shredding toilet paper.

Despite there often being up to 15 people in the main lounge there were not always staff members present. When we observed call bell panels we saw that bells were not attended to for more than 15 minutes on occasions.

The provider told us that during the day there was one senior and a care staff member in The Coach House and overnight one staff member. We saw that medicines administration had been delayed in the mornings because both staff members were needed to assist people with their breakfast until 9:45 am. We were told that if the night staff member in The Coach House needed assistance then they could call on staff in the main part of the home. However, this would leave one care staff member supporting 25 people, several of whom needed staff support to mobilise safely.

The provider did not calculate staffing arrangements based on people's dependencies, but on a ratio of 1staff member for 5 people in the main part of the home, i.e. 5 staff members for the 25 people. However, one of the five staff members was a kitchen assistant and another was the senior on duty, both of whom had significant other

Inadequate

Is the service safe?

responsibilities. Overnight there were two care staff in the main part of the home. We were also told that a cleaner worked nights as well and they were able to assist if necessary.

Sufficient staff were not deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A staff member who joined the service recently told us that they had been required to provide references, proof of identity and their backgrounds had been checked to ensure they were suitable to carry out their duties. We reviewed recruitment files for three staff members. We found that whilst appropriate checks had been carried out in respect of two staff members, no references had been sought for one staff member. The service had not taken all necessary steps to ensure that people were supported by staff with verifiable backgrounds.

During our two day inspection we found that the cleanliness of the home required attention. Extractor fans in bathrooms were clogged with dust and dirt. On the top floor we noted stained mattresses. Some toilets were stained dark well below the watermark. The rear corridor smelled unpleasant. The carpets in some bedrooms, particularly in The Coach House, were badly stained and some rooms smelled unpleasant. A used glove was found on the floor of the downstairs bathroom. This bathroom contained a bath chair with a dirty base plate, the bath seat was stained and a bath mat that was not clean.

These concerns meant that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

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

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 checked whether the service was working within the principles of the MCA and found that it was not. Neither the provider nor the manager was clear what the DoLS were. Some staff told us they had received training in the MCA and DoLS and some said they were booked to have this training. However, none of the staff we asked could tell us anything about the MCA or DoLS. We found that no mental capacity assessments had been carried out despite care records stating that individuals had 'no capacity'. A DoLS application had been made in respect of one person by the manager.

We were unable to establish whether people had consented to aspects of their care. Decisions had been made that could potentially restrict people's rights, but we could not confirm that people had consented to the actions taken. For example, the PIR stated that The Coach House had been set up to support people 'with less capacity and more challenging behaviour…to keep their dignity and privacy….and ensure a safer environment for them. It also eliminates the risk to other people of abuse.' People living in the home we spoke with were not able to tell us about their experience of the care they received. We could not establish that people living in The Coach House had consented to moving in to this area, or that if they couldn't, the decision had been made in their best interests.

We could not confirm whether people had consented to some arrangements in place which were potentially restrictive because they could not tell us and there were no records to show how the decisions had been made. For example, pressure mats were in use in several people's bedrooms to alert staff if people were moving. We observed that several people were receiving pureed food but we were unable to communicate with them to see if they had consented to this. The cook told us that care staff monitored generally if people were unwell, for example who had dentures or were coughing and then a soft diet was provided. The cook also advised that people did come off soft diets and said, "If we puree food, there's no risk."

The service did not have a policy on the MCA, however a DoLS policy was in place. Staff did not have adequate reference material for these topics to help them to ensure that they promoted and protected the rights of people who may lack capacity to consent to their care.

The provider was not acting in accordance with MCA when people lacked the mental capacity to make decisions for themselves. They were in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We heard staff asking for people's agreement before tasks were carried out throughout our inspection. One person told us, "I feel the staff ask my permission about everything and if I say no they respect that." However, one person who had been sitting the lounge all morning told us, "I go where they put me. I don't have much choice."

People were not adequately supported with their nutritional requirements. Most people did not have drinks within reach unless they were having a meal or the tea trolley had been around recently. There were not enough tables beside chairs in lounges to ensure that people had somewhere to put a drink if they had one. Several people had their fluid intake monitored, but staff could not tell us how much individuals needed to drink to keep sufficiently hydrated. Quantities were not being recorded on the charts. Therefore, staff were unable to determine whether people at risk of dehydration were having enough to drink.

Staff did not understand the nutritional screening tool they were using. All three care plans we reviewed in detail had calculation errors in determining the risk of not eating enough due to not factoring in the additional risk from weight loss. Staff were not following the nutritional tool guidance on what action to take if people were assessed as at nutritional risk. The care records for one person who had lost a significant amount of weight over a three month period stated, 'Encourage extra high nutritional snacks

Is the service effective?

between meals'. However, food charts were not being kept so we could not confirm whether this was being done. Staff told us there were no defined rules on when to record people's food and fluid intake or how to use the information from them.

The care records for another person who had a low weight also stated that staff should, 'Encourage extra high nutritional snacks between meals'. Food charts were in place for this person, but several snacks between meals were recorded as 'tea' or 'biscuit'. Staff could not be sure that the person's nutritional intake was adequate or being enhanced as required.

We were told that a third person was on a 'soft' diet because they had been assessed by a speech and language therapist (SALT) as at risk of choking. However, there was no SALT assessment in the person's care records or in the kitchen. The manager could not find any professional guidance in relation to the person's nutritional needs. The cook was not aware of NHS dysphagia descriptors which gave clear guidance on diets recommended by SALT professionals. Therefore, the service could not demonstrate that the person was receiving food that was of a suitable texture for them to eat.

The manager and the cook told us that they ascertained people's likes and dislikes. The cook told us that there was a second choice for each lunch and evening meal incorporated into the menu which was changed every two weeks. However, people were not routinely offered the second option; it was given to them if it was known that they disliked the main selection. There was no way of supporting people with cognitive impairments to make a meaningful choice about what food they would like to eat.

We determined that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "The food is okay here, has got better I think. We can choose something else if we do not like the meal." Another person said, "I am diabetic and they know what I can eat as well as what I like or dislike eating." A third person told us, "We get plenty to eat but the weekly menu seems to be the same. You can have a snack if you want, although I have never asked."

Staff told us that training was now more available since the new manager took over and that it had, "....come to a bit of a stop beforehand." Some staff told us they would be starting diplomas in the new year which had been agreed by the provider and manager. The provider told us that they were not sure who had completed what training from the records left by the registered manager, so they had decided to start afresh.

The majority of staff had received recent training in several areas. Training was booked for January 2016 in medicines management, challenging behaviour and fire safety. However, the manager was unable to demonstrate that staff authorised to handle and administer people's medicines had received training and had been assessed as competent to undertake these tasks. There had been no training for staff in the MCA or DoLS.

Annual appraisals had not taken place and some staff told us they had not received supervisions. There was supervisory system in place which was an observational supervision which was carried out by senior staff. This comprised of a tick list of staff competencies. However, where it was identified that staff required training, for example, on catheter care, this had not been arranged. The manager told us that supervisions hadn't always been happening, but they would be starting in the new year.

Staff did not always receive the training, supervision and appraisals they required to ensure they were able to meet people's needs effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I see the doctor when I need to and staff will come with me on my hospital visits." We spoke with the GP who visited the service most days due to the complex health requirements of many people living in the home. The GP told us that senior staff always accompanied them when they visited people and that staff implemented their advice and guidance effectively.

However, we found instances where people may have benefitted from the expertise of specialist health professionals, but no referrals had been made. For example, the person we identified as having a low weight may have required the input of a dietician. The person who was sat on a beanbag should have had their physical needs assessed by an occupation therapist to determine what type seating would be most appropriate for them.

The Coach House was poorly lit in some communal areas, as was the rear corridor in the main house. This did not support people living with dementia or impaired vision to

Inadequate

Is the service effective?

function safely and with ease. Signage was poor in The Coach House. On day two of our inspection we found that attempts had been made to improve this since the first day of our inspection. People had pictures on their bedroom doors of things or people of relevance to them. These were laminated and shiny, which didn't make the details easy to see and were not fixed securely which meant they were likely to fall off. The environment was not stimulating for people living with dementia. There was nothing for people to pick up, touch or look at. The television was on, but no-one was watching it. People spent their time asleep or walking about.

Requires improvement

Is the service caring?

Our findings

Some people were positive about the staff that supported them. One person told us, "There are lovely, kind people here who really care about us and treat us well." Another person said, "Everyone is very kind here and put me right when I get in a muddle. They just tell me 'never mind'." A third person told us, "It's marvellous here." A fourth person told us, "There have been a lot of staff changes here and half the time we do not know who is looking after us. I like to know the staff and to be cared for by those I know and trust. There is some lovely staff here that I know really well and they know me." Another person told us, "I needed a new pair of stockings because my old ones had holes in them. Staff soon went a bought me a pair. You only have to ask and most of them will help. But I wouldn't ask the ones I know would forget."

Other people indicated that some staff were not as good as others. One person said, "Most of the staff are nice and kind, but one or two can be abrupt." A third person we spoke with told us, "Carers? Some are good, some are hopeless. Not all of them listen to you." Another person told us, "Staff are not always in a good mood when they have a lot to do."

One staff member told us that whilst most of the staff were kind and caring a few were not and they lacked compassion and warmth. They told us that when incidents of concerns were raised with the manager they were addressed. They told us they believed in treating everyone in the home like they would one of their own family members and took the time to listen to people and be at the eye level with them.

When staff were present we observed positive interactions between them and the people being supported in The Coach House. Reassurance and acknowledgement of people's feelings were used to good effect when people became anxious. Staff explained clearly what they intended to do to assist people, for example, help a person put their slippers on. If people declined to do things at staff suggestions, people's decisions were respected. Staff were polite and treated people with respect. Bathroom, toilet and bedroom doors were closed when people were being assisted with personal care.

In the main part of the home people who made their own way to the dining tables for lunch chose where to sit. People being supported by staff were asked where they wanted to sit. However, interactions between staff and people who required assistance to eat their meals were poor. One staff member was diligent in ensuring that the person they were supporting had finished one mouthful before offering them the next one. However, there was little attempt at dialogue with the person other than the staff member asking if the person was ready for another spoonful. The staff member was stood up in front of the person with one hand on the person's chair. A new staff member who was shadowing the carer stood behind the person, also with their hand on the person's chair. This was not respectful, did not promote the person's dignity and may have felt oppressive. The staff member said to the shadow staff member, "[The person] used to be a [profession] so they don't like to be told what to do, so be careful."

A second person also required the support of staff to eat their lunch. The staff member attempted little conversation with the person. Another person asked a staff member what was in their sandwiches and this was explained to them. The person was asked to eat as much as possible. The person asked, "Do I have to eat it?" and was told that they did not. A few moments later the person was again encouraged to eat their lunch but they clearly didn't want to do so. They were not offered an alternative.

The main meal was at 4:30 pm, with sandwiches at lunchtimes. The manager told us they had found that people were not that hungry at lunchtime and that they felt this helped encourage people's appetites and "….burn calories." They told us that people had not been asked when they would prefer to have a main meal.

There was little to show that people, or their relatives, were involved in the ongoing planning of care. We reviewed care records of people with high levels of need that were not able to contribute in any detail to say how they wished to be supported. There were scant records of any conversations with the families of these people. The manager told us that they planned to involve families every three months with care plan reviews, but this hadn't yet been implemented.

Inadequate

Is the service responsive?

Our findings

People's care was not planned in a person-centred way designed to meet all of their needs. We found considerable shortfalls in people's care planning. There were no plans of care drawn up to respond to risks that had been identified. Risk assessments and care plans were effectively the same document which was reviewed on a monthly basis. This document, whilst identifying risks, gave scant detail for staff on how to mitigate the risks. Risk assessments often stated, 'Action needs to be taken by all staff' but few, if any, details were given. For example, where one person had been assessed as at risk of skin breakdown, there were no details to show what equipment was being used to help prevent this.

Several people were living with significant health conditions, such as Parkinson's, diabetes and mental health conditions. However, there were no care plans to reflect people's individual needs or the associated risks that arose from those health conditions. There was no recognised tool in place for the assessment of pain for those individuals who could not verbalise their feelings. Staff did not have access to the information they needed help identify and meet people's needs.

Some people periodically exhibited behaviour that was very challenging for staff, such as the removal of clothing, crawling on the floor or aggressiveness towards others. Whilst staff told us how they managed these behaviours and recorded the events, there was no analysis of what was happening in the lead up to these behaviours or what may have triggered them. This information could have been utilised to foresee when these behaviours might occur and steps could then be taken to avoid the behaviour in the first place.

People told us there was nothing to do during the day. One person told us, "I can't walk much outside because of a lack of paths. I've been out all my life and now I'm cooped up here." Another person said, "We do have things arranged here, but it's a bit late for me. But I like the singers when they come." A third person said, "There's not much for men to do here. We all just watch the television most of the time."

People's preferences were noted in their care records, for example, when they liked to get up and go to bed and whether they liked their door open or closed at night. We found that some people, or their families, had recorded information about their life histories but we did not see this used effectively, for example to plan activities which reflected people's individual interests. We were told by the manager and provider that the activities staff member worked between 6 and 9 pm three evenings a week. Whilst this suited a few people, it left the majority with long periods during the day with nothing to do. A domestic staff member who, once they had finished their regular duties, was able to spend an hour during the day to paint nails or take people to the shops. There was no information available in the communal areas to show what events were planned so people would know what would be happening and when.

A few people read papers or magazines. However, most people, including those in The Coach House, had nothing to occupy their time with and sat in chairs sleeping, watching others or walking about the communal areas of the home. Some people required staff input to help motivate them to interact with others and maintain their cognitive skills. Staff were aware of the lack of social stimulation and limited emotional support but had little time available to support people with this as they were busy meeting people's immediate physical needs.

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

People told us that their concerns and complaints were listened to and resolved as they occurred. They told us they were happy to speak with staff, the manager or the provider if they had any issues and felt confident that their concerns would be taken seriously and acted upon.

A survey of friends and family had been sent out just prior to our inspection. In October 2015 staff had supported nine people to complete a questionnaire on the service they received. The comments were broadly positive. There were a few adverse comments or suggestions for improvements such as; "Some staff can be rough", "I'd like to go out more and a lock on my bedroom door" and "I'd like to do some gardening." However, there had been no response to remedy the concerns raised or act upon the suggestions of these individuals.

Inadequate

Is the service well-led?

Our findings

Providers and registered managers are required under the Care Quality Commission (Registration) Regulations 2009 to notify CQC of significant events that affect people's welfare, health and safety so that, if necessary, CQC can make further enquiries to ensure that appropriate action has been taken. In a three year period we had only received one notification from the service. This was made by the provider, after the registered manager had left the service, in relation to a safeguarding incident. Our inspection found that there were four recent safeguarding incidents we hadn't been notified about and two historical injuries that should have been reported. Staff told us that people had passed away in the home over the last 12 months, which we would have expected. However, we had not been notified of any deaths at the service since October 2014.

As a result the provider is in breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

Whilst there were adequate checks made of equipment in the home, there were few audits to establish the quality or safety of care that people that received. Infection control audit documentation was in place, but the checks had not been implemented. There was an annual audit carried out by the pharmacy that supplied people's medicines but no ongoing system of checks was in place to ensure that people's medicines were managed and administered safely or that staff were competent to do so.

The way that people's fluid intake and night time repositioning was recorded was not fit for purpose and this had not been identified. Due to poor recording practices and the absence of any analysis we were unable to determine the level of falls within the home and whether they were being acted upon appropriately.

Care plans were not subject to review to ensure that they contained sufficiently detailed and personalised up to date information to enable staff to support people appropriately.

The complaints information on the back of people's bedroom doors referred people to an obsolete organisation if they were not satisfied with the manager's response. There was no reference to people being able to escalate their concerns to the provider, the local authority or the Local Government Ombudsman. This needed updating.

The provider carried out two monthly audits of the service. They spoke with people and reviewed records. However, these audits had a very 'light touch' approach, lacked detail and had failed to identify the issues we found during this inspection.

No resident or relative meetings had been held for a considerable period of time. This meant that there were limited opportunities to inform people about what was happening, what the service's plans were and obtain people's views in order to help drive improvement.

When the pharmacist inspector reviewed medicines we found that there were charts in place to record the application and removal of skin patches, however, there were gaps in the records. When people were prescribed medicines on a when required basis, there was sometimes, but not always, written information available to show staff how and when to administer these medicines. For medicines prescribed in this way for the management of people's psychological agitation there was insufficient written information about this and a lack of records showing why the medicines were needed. Additional records for the administration of medicines prescribed on a when required basis were confusing and often not completed. Therefore people may not have had these medicines administered consistently and appropriately

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

The registered manager had left the service in November 2015, but had not yet applied to cancel their registration. The deputy manager had taken on the manager's role and was leading the service with support from the provider two days a week. Both the manager and the provider recognised that there was a lot of work that needed to be done to improve the service. However, they had not anticipated the extent of the concerns we found during this inspection.

Staff told us that the culture of the home had improved considerably with the change of manager and that both the provider and manager were keen to take their views and suggestions on board. Staff meetings were being held

Inadequate

Is the service well-led?

regularly. Comments included; “It’s a good place to work since the new manager has been in place.” The provider and the new manager are much more positive.” “Staff morale has really improved and we are now working as a team.”

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Service users were not protected because the provider had not ensured that safeguarding incidents were identified and acted upon appropriately. Regulation 13 (1)(2)(3)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way because risks were not always identified and mitigated, people's medicines were out of stock and infection control measures were not effective. Regulation 12 (1)(2)(a)(b)(f)(h)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Sufficient numbers of staff were not deployed to ensure people's needs were met. Staff did not receive adequate training or support. Regulation 18(1)(2)(a)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider did not act in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11(1)(3)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: The nutritional needs of service users were not met because the provider had failed to adequately support people with their food and fluid requirements and people were not offered choices. Regulation 14(1)(4)(a)(c)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The provider did not provide person centre care because people's care was not assessed or planned for to ensure their needs and preferences were met. Regulation 9(1)(3)(a)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

How the regulation was not being met: The provider did not have systems in place to identify or address issues that affected the quality of the service people received or the risks they were exposed to or maintain accurate medicines records.

Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The provider was not notifying the Care Quality Commission of service user deaths. Regulation 16(1)(a)(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider was not notifying the Care Quality Commission of reportable incidents Regulation 18(1)(2)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.