Ms Monica Maxwell

Francis Lodge Residential Home

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?	Inadequate
Is the service well-led?	Requires improvement

Overall summary

Francis Lodge Residential Home is a privately owned residential care home. It provides personal care and accommodation for a maximum of four older people who may have dementia. During this inspection, there were four people using the service.

There was manager in post who is the registered provider of this service. 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. As the provider is an individual they are not required to also have a registered manager. At this service the registered provider is also the manager. We call the registered provider / manager "the provider" throughout the report.

At our last inspection of 23 December 2014, the provider had not taken appropriate steps to ensure there were sufficient staff numbers in the home. This meant the

Summary of findings

provider was in breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider sent us an action plan setting out the actions they would take to meet the regulation. At this inspection, we found that the provider had followed their action plan and met the regulation. We observed and records showed two members of staff were allocated during the morning and there were sufficient staff available during the day.

Although there were some positive aspects to the service such as people were being cared for and supported to have access to healthcare services, we found failings in each of the five domains resulting in people who used the service receiving lower standards of care than they should.

Individual risk assessments were completed for each person. However, the assessments contained limited information and some areas of potential risks to people had not been identified and included in the risk assessments. For example three people using the service all need support with their mobility however there were no risk assessments in place to prevent the risks of falls occurring.

Care plans were not person centred and did not reflect people's current needs. Complete and contemporaneous records had not been kept about people's care and support they needed and were receiving.

There were suitable arrangements in place to manage medicines safely and appropriately.

Training records showed staff did not receive regular and appropriate training for them to gain the necessary knowledge and skills they needed to carry out their roles and responsibilities effectively.

We saw people being treated with respect. Care workers had a good understanding and were aware of the importance of treating people with respect and dignity and respecting their privacy.

People were supported to maintain good health and have access to healthcare services and received on going healthcare support.

Although the provider had contact with people's relatives, there had been no formal review meetings with people using the service and relatives in which people's care was discussed and reviewed to ensure people's needs were still being met and to assess and monitor whether there had been any changes.

Three people using the service were elderly with dementia care needs, however, there were no reasonable adjustments made to the environment of the home to ensure it was a dementia friendly and help people to recognise and navigate around the home.

The management structure of the home consisted of the provider and a team of care workers including two volunteers. However, the roles of the volunteers were not clearly defined which could place people at risk of receiving support which is inappropriate.

We made three recommendations about reviewing safe recruitment practices, surveillance being operated in line with current guidance and reasonable adjustments for people with dementia.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Some aspects of the service were not safe. Some risks were identified so that people were safe and protected. However, information was limited and did not address all of the risks to the health and safety of people receiving care.

There were recruitment and selection procedures in place to ensure people were not at risk of being supported by people who were unsuitable.

There were suitable arrangements in place to manage medicines safely and appropriately.

Requires improvement

Is the service effective?

Aspects of the service were not effective. Staff did not receive regular and appropriate training for them to gain the necessary knowledge and skills they needed to carry out their roles and responsibilities.

There were some arrangements in place to obtain, and act in accordance with the consent of people using the service, however there was a lack of understanding by the provider and care workers of the Mental Capacity Act 2005 (MCA) and DoLS.

People were supported to maintain good health and received on going healthcare support.

Requires improvement

Is the service caring?

Aspects of the service were not caring. People received care and support which was more task focused.

No formal review of care meetings had been conducted with people and their relatives in which aspects of their care was discussed.

People were being treated with respect and dignity.

Requires improvement

Is the service responsive?

Aspects of the service were not responsive. People using the service were not receiving person centred care and were not engaged in meaningful activities.

Complete and contemporaneous records had not been kept about people's care and support they needed and were receiving to demonstrate their needs were being met.

The provider told us no complaints had been received about the service but was unable to find the complaints records folder during the inspection.

Inadequate

Summary of findings

Is the service well-led?

Some aspects of the service were not well led. There were systems in place to monitor the quality of the service however we found some deficiencies in the service had not been identified.

The management structure in place was the provider and a team of care workers including two volunteers. However the roles of the volunteers were not clearly defined

Some health and safety checks had been carried out in the home.

Requires improvement

Francis Lodge Residential Home

Detailed findings

Background to this inspection

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

This inspection was carried out by two inspectors. Before we visited the home we checked the information we held about the service and the service provider including notifications and incidents affecting the safety and well-being of people.

There were four people using the service who had a range of significant and complex needs including one person who was deaf. People's communication was limited due to their complex needs. Because of this, we spent time at the home observing the experience of the people and their care, how the staff interacted with people and how they supported people during the day and meal times.

We spoke with the provider and one care worker. We also spoke with one relative. We reviewed four people's care plans, three staff files, training records and records relating to the management of the service such as audits, policies and procedures

Requires improvement

Is the service safe?

Our findings

At our last inspection on the 23 December 2014, the provider had not taken the appropriate steps to ensure there were sufficient numbers of staff in the home. This meant the provider was in breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider sent us an action plan setting out the actions they would take to meet the regulation. At this inspection, we found the provider had followed their action plan and met the regulation. We observed and records showed two members of staff were allocated during the morning and there were staff available during the day.

Records showed there were staff rotas in place and there were two to three care workers on duty during the day and one during the night. We asked a care worker whether they felt there was enough staff in the home to provide care to people safely. The care worker told us there was enough staff, but, "we can be busy." One relative told us they did not have any concerns about the staff however they did tell us that "There have been lots of different staff over the years. Most of the time I see the [provider]."

The rota also showed the provider worked shifts during the week. During the inspection we observed that the provider was on shift and carried out most of the tasks herself including providing personal care to people using the service, cooking, cleaning and dealing with visitors. The provider was also responsible for the day to day management of the service and record keeping. Care workers were not being delegated by the provider to carry out any specific tasks and were mostly instructed by the provider on what they needed to do.

We looked at the recruitment records for three members of staff and found appropriate background checks including enhanced criminal record checks had been undertaken to ensure staff were not barred from working with vulnerable adults. Two written references and proof of their identity and right to work in the United Kingdom had also been obtained.

During the inspection, the provider's son arrived and we observed that he helped with putting up the Christmas decorations and any other chores that needed to be done in the home. The home also has a volunteer that came to the home during the week who would usually sit with people and engage with them and would also sometimes be referred to as an activities person.

We spoke to the provider about this as we had concerns as to their roles at the service and whether the appropriate checks had been done to ensure people using the service were safe and not at risk of being supported by people who were unsuitable. The provider told us that both people were volunteers at the home and that they knew the people using the service well but were not involved with providing people with personal care. The provider was able to show us appropriate Disclosure and Barring Service [DBS] checks had been obtained for both volunteers which were satisfactory.

However it was unclear as to what the roles of both volunteers were, their specific duties and times which they would be coming to the home. There was no evidence to show that the correct procedure had been followed in recruiting the two volunteers as there was no applications forms, job descriptions and references obtained to demonstrate the volunteers were suitable for their roles. There were also no records which demonstrated volunteers had been appropriately trained and supported for the roles they undertook.

We recommend the provider seeks advice and guidance on safe recruitment practices and ensure staff/volunteer roles are clearly defined.

We found evidence that risks were not being appropriately assessed and managed which put people at risk of receiving care which was not safe,

Records showed some risks to people were identified for their safety. Individual risk assessments were completed for each person using the service which helped ensure they were supported to take some risks as part of their daily lifestyle with the minimum necessary restrictions. Although there were some risk assessments in place, we noted the assessments contained limited information and some areas of potential risks to people had not been identified and included in the risk assessments.

For example, in one person's care plan, we noted there was reference to them having falls in their previous care home and there was some information about their mobility in their care plan, however there was no risk assessment in place for this. Three people using the service all needed

Requires improvement

Is the service safe?

support with their mobility and to walk however there were no risk assessments in place for falls, the potential risks inside and outside the home and what precautions were being taken to ensure people were safe and protected from falls.

Two people using the service needed to use a stair lift to access their bedrooms upstairs. Although there was a stair lift risk assessment, the information was very limited for what staff had to do. The risk assessment mentioned staff to ensure the safety belt was in position and feet were correctly placed on the foot place but there was no other information on the possible risks to the person, observing people whilst they were on the stair lift and what support was needed for the person once they had reached upstairs. There was also no mention whether another member of staff would be needed to be upstairs to receive them and what support the person would need to get out of the stair lift and into their bedroom. The risk assessment also did not include what measures were in place for people if the stair lift malfunctioned and if the stair lift stopped working.

One person using the service used a wheeled walking frame as they were unsteady on their feet and required support with their balance. The person's care plan covered some information on the person's walking ability however there was limited information about the safe practice and risks associated with using such equipment and appropriate moving and handling techniques required by staff. In one person's care plan reference was made to a shower stool being used however there was no information on any potential risks for people when receiving personal care in the bathroom.

Training records showed staff were not sufficiently trained to provide the appropriate care specific to people's needs. We looked at staff training records which showed care workers has not received any recent manual handling training. Records showed that two care workers had last received training in manual handling in March 2013 and for three care workers the training was recorded as 'pending'. The lack of regular and current training in the correct and safe moving and handling techniques for staff puts people using the service at risk of receiving inappropriate and unsafe practice of moving and handling which could cause significant harm as there people using the service are elderly and frail and have mobility needs.

In one person's care plan, there was some information that they were at risk of a seizure but there was no specific information which showed how this was managed by the home and what action staff would need to take if the person had a seizure. Records showed the person had recently suffered from a seizure, although the appropriate emergency services were called, there were no updated risk assessments in place to ensure this person's epilepsy was being monitored and that appropriate measures were in place to effectively manage and respond to any further seizures.

We found that risks were not being assessed. Information in two people's care plans showed that they could at times display signs of behaviour that challenged the service. However, there was no risk assessment in place to show what type of behaviour the person would display and what the possible triggers were which could lead to such behaviour being displayed. There was also no information which detailed the social and emotional support that was required by staff to help the person feel at ease and proactive strategies to minimise the impact of behaviours displayed to keep people safe. Records also showed that care workers had not received any training on challenging behaviour which meant they were not competent to manage and address incidents when people displayed behaviour that challenged the service.

Accidents and incidents were recorded and showed any necessary action had been taken. However, records did not show any follow ups of the incidents. For example, risk assessments had not been updated and did not detail measures put in place to minimise the risk of another reoccurrence and ensure the person was safe from further incidents.

The above evidence demonstrates that the assessment of risks to the health and safety of people using the service was not being done appropriately. All the risks were not being identified for people and their specific needs which meant risks were not being managed effectively and this could risk people receiving support that was not appropriate and unsafe.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care worker we spoke with knew about the signs of abuse and how to report any abuse to the provider. The care worker also mentioned the local authority but needed prompting to report to safeguarding adult's team in the local authority. A safeguarding policy was in place.

Requires improvement

Is the service safe?

There were suitable arrangements in place to manage medicines safely and appropriately. We looked a sample of the Medicines Administration Record (MAR) sheets and saw they had been signed with no gaps in recording when medicines were given to a person. There were arrangements in place in relation to obtaining and disposing of medicines appropriately from a local pharmaceutical company. Records showed and care workers confirmed they had received medicines training and policies and procedures were in place.

Requires improvement

Is the service effective?

Our findings

We looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. Records showed that some staff members had obtained National Vocational Qualifications (NVQs) in health and adult social care.

However we found evidence that staff did not receive regular and appropriate training and supervision for them to gain the necessary knowledge and skills they needed to carry out their roles and responsibilities effectively. The training received by staff was inconsistent. For example, during 2015, one care worker only received medicines handling and end of life training. Another care worker only received safeguarding and infection control training and a third care worker had not received any training in 2015. Records showed training was 'pending' but there was no indication as to when the next training would be available. The provider told us that training was due for staff and in the process of being arranged but could not show us any evidence during the inspection that the training had been booked or was being arranged.

One person using the service was deaf and communicated using British Sign Language (BSL) however records showed that none of the care workers have received training in sign language. The home has one care worker who is deaf and is able to communicate with the person however the care worker has particular shifts during the week and was not at the home at all times. Another person using the service has a mental health condition however records showed care workers had not received any training in mental health and on how to manage and support a person with mental health needs.

The needs of people also required staff to use appropriate manual handling techniques and to manage challenging behaviour effectively however records showed staff had not received any recent training in manual handling and challenging behaviours.

We looked at three staff records and although staff had received some supervision and appraisals in previous years, records did not show any recent supervisions or that they had been conducted on a regular basis. One care worker told us, "I have not had an appraisal yet" and one staff record showed the last supervision they had was 2013. One care worker did tell us that they received supervision meetings however staff records did not reflect this. We spoke to the provider about regular appraisals and she told us supervisions had been done recently but was unable to produce evidence of this. There was also no evidence which showed spot checks had been completed for staff to assess their competency.

The above evidence demonstrates care workers did not receive sufficient support and training to enable them to carry out their roles and responsibilities. Care workers performance had not been assessed to ensure care workers were competent enough to support people appropriately with their needs.

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

There were some arrangements in place to obtain, and act in accordance with the consent of people using the service, however there was a lack of understanding by the provider and care workers of the Mental Capacity Act 2005 (MCA).

Records showed where a person was unable to give consent about a particular decision, the person's relatives, healthcare professionals and a power of attorney were involved to ensure decisions were made in the person's best interest. However people's care plans contained limited information about people's mental capacity and cognition. No mental capacity assessments had been completed for each person even though in one person's care plan it stated the person would get confused, had poor memory and needed prompting to remember things. Some people using the service may also suffer from dementia and would need the appropriate support to help them make decisions where they can. Records did not show what support people were been given to make decisions where they are able to.

Information in people's care plans detailed where people would need support and supervision but it was sometimes unclear why a person would need such support in specific areas. The care plans did not state why the person would require support and whether it was because of the person's level of mental capacity, a particular health need, safety reasons or the person's choice to want such support provided for them.

Records showed that staff had not received training on the MCA. When speaking with care workers, they were not able to explain what mental capacity was but showed an understanding of some issues relating to consent.

Requires improvement

Is the service effective?

The above evidence demonstrates people's mental capacity to consent to care and treatment had not been appropriately assessed. The provider and care workers had limited understanding of the implementation of the Mental Capacity Act 2005 (MCA).

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

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes which protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Records showed the provider had applied for DoLS authorisations for the people using the service as it was recognised that there were areas of people's care in which the person's liberties were being deprived. There were two authorisations in place and the provider told us they were waiting for a response from the relevant local authorities for two more applications.

During the inspection, we noted there was a CCTV camera near the kitchen area. We spoke to the provider about the camera and she told us the camera was not on and had to be activated which could be done by her mobile phone.

We discussed this further with the provider that the appropriate policies and procedures needed to be followed to place such surveillance equipment in a home. The provider was unable to demonstrate that this form of surveillance had been put in place in the best interests of people using the service and was not mindful of her responsibilities towards staff, relatives and visitors as consent had not been sought. When we asked one care worker about the camera, they told us that they were not aware of it until we had mentioned it. One relative also confirmed they were unaware that there was a camera in the home and the reasons why it had been installed.

The provider indicated that she wasn't fully aware of the procedures and would look into this matter and the camera was not on.

When speaking with care workers, they were not aware of how people's liberties could be deprived and were not aware of the differences between lawful and unlawful restraint practices. Records showed care workers had not received any DoLS training.

We recommend that any surveillance should be operated in line with current guidance.

People were supported to maintain good health and have access to healthcare services and received on going healthcare support. Care plans detailed records of appointments by healthcare professionals including GPs, chiropodist and opticians. During the inspection, a GP came to see two people using the service for a check-up.

The information in people's care plans about their eating and drinking was limited to what they liked to drink and included broad statements such as 'prefers to choose their meals throughout the day. Staff to offer [person] a choice'. However there was no further information as to people's likes and dislikes and the type of food they enjoyed. In one person's care plan it stated the person suffers from malnutrition and staff to monitor food intake. It was unclear as to how this was being monitored as there were no records to show this was being done and records showed that the person was not being weighed on a regular basis. In the person's care plans, it did state that the person had lost weight and was prescribed with a nutritional drink however there were no records to show how this was being monitored, when and often the person should take this drink and for how long.

We spoke to one care worker who was able to tell us what people liked and didn't like and that people using the service ate well. There was a set menu in place and the care worker told us there was always a choice if people wanted something different.

We observed people using the service were given drinks and snacks throughout the day and care workers respected and adhered to people's choices and wishes. During lunch, we observed the food was freshly cooked and nutritious. People had varied meals for example one person had chicken and others had shepherd's pie. In one person's care plan it stated they enjoyed spicy food and they were offered some spicy sauce to accompany their meal. We observed care workers supported and prompted people only if it was needed. People using the service ate independently and appeared to enjoy their food and ate everything on their plates.

We observed reasonable adjustments had not been made in the home in response to people's specific needs. Three people using the service are elderly and may suffer from dementia however there were no adjustments made to the

Requires improvement

Is the service effective?

home to ensure it was a dementia friendly environment such as signage, contrasting colours and pictures that could help people with their memory but also help people to recognise and navigate around the home. There was poor lighting in the living room area which could be of risk for people with dementia, visual and mobility needs. We also noted that there was no End of Life information in people's care plans, as people were very elderly, which detailed how people wished to be cared for and the appropriate support they would require. We spoke with the provider who seemed unsure as to what this meant and clarified that information detailing End of Life care for people needed to be included and acted upon as part of their care.

We recommend that the service seek advice and guidance from a reputable source about adjustments required to meet the needs of people living with dementia.

Requires improvement

Is the service caring?

Our findings

One relative told us the home was, "Okay(ish)," and, "It's nice there aren't too many people in the home. It's better for [person]."

During the inspection, we observed that people were relaxed and free to come and go as they pleased in the home. Care workers were patient when supporting people and communicated with people in a way that was understood by them. We observed people were comfortable with each other.

We saw people being treated with respect. When speaking to care workers, they had a good understanding and were aware of the importance of treating people with respect and dignity and respecting their privacy. We observed one care worker who had a nice rapport with one person using the service as the person was smiling as the care worker spoke with them.

However during the inspection, we observed the care and support provided to people was more task focused and there was limited engagement with people using the service which was meaningful or stimulating. People's care plans detailed some information on how to communicate with people, however we observed that some of the information in people's care plans was not being followed. In the care plan for the person who was deaf, it stated that they could communicate by signing and writing. The care plan also stated that staff were to ensure the person had a note book and pen at all times and to communicate with the person by signing and as staff had not received any training in sign language to use the note book. During the inspection, the person did not have the notebook with them and staff did not encourage for the book to be used when communicating with the person. Staff communicated with the person by speaking to them and using hand gestures. We spoke to staff about this and they told us that the person was able to lip read however this was not stated in the person's care plan.

The care plans of three people using the service who were elderly stated people were either forgetful, confused or had troubling remembering, However records did not show how people were supported and encouraged to be involved and made to feel their views and preferences were being listened to. For one person using the service who seemed to demonstrate some capacity and could clearly communicate verbally, we noted their care plan had been reviewed by the provider however records did not show the person's views and involvement had been sought as part of the review of their care. People's care plans had also not been signed which indicates a lack of involvement from people using the service and their relatives.

There was evidence that family relatives and representatives were involved in people's lives and would visit the home and were informed if there were any concerns with people's health. However there were no formal review meetings with people using the service and relatives in which people's care was discussed and reviewed to ensure people's needs were still being met and to assess and monitor whether any changes had taken place. One relative told us "[Provider] calls me if anything happens and is very friendly. We may speak about the care plan about once a year but there is nothing formal. It is just a chat whilst I am visiting the home."

Although care plans had some information about what people liked, there was a lack of arrangements in place which ensured people were supported to be involved and to express their needs and preferences in any way they were comfortable with and that these personal preferences were listened to and acted upon.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People's care plans consisted of an All About Me document and Care Support Plan. The care plans provided some information about the people's life history, medical background previous occupations, things people liked to do and people who were important to them in their lives. The care plans also provided some detail about the support people needed with various aspects of their daily life such as personal care, continence, eating and drinking, communication, mobility and medicines.

However, the support plans were difficult to follow and information about people's support was not recorded clearly and was sometimes contradictory. Some information was also left blank in some records. For example in one person's All About Me document, social activities, likes and dislikes and my fondest memory were left blank, we then found some of this information in their care support plan. Under the section TV, radio and entertainment was again left blank however we then noted that in the person's care plan that the person takes comfort from watching sports on TV.

For one person, who had specific mental health needs, the information contained in their pre admission assessment was limited and some sections such as reason for admission, past occupation, activities, mental alertness and anxieties were also left blank. The information detailed in the person's pre admission assessment was not comprehensive enough to ascertain whether the home would be able to accommodate and be responsive to the person's specific needs yet this person was still admitted into the home. The assessment did not clearly set out how the person's needs would be met by the provider.

This person also had alcohol related issues but there was limited information and adjustments made to ensure this person had the emotional support in place for them to manage their conditions. The provider told us that due to some behaviour that had challenged the service, she had given notice regarding their placement for review of the persons own safety and other people living in the home.

Some information in people's care plans was contradictory. For example, in one person's care plan it stated the person not to take public transport as their behaviour can be challenging but then it goes onto state that two care workers were needed to escort the person on the bus.

There was also no further information about what the challenging behaviour was, how it was triggered and how the staff were meant to support the person and reduce the risk to the person and others.

It was unclear how other aspects of people's needs were being monitored. For example in one person's records there was some general guidance for pressure ulcer prevention and turning instructions in the person's bedroom however there was no specific guidance on how to prevent a pressure ulcer such as by positional change and responsive personal care.

One person using the service had diabetes and another person suffered from epilepsy seizures however there was limited information as to how these conditions were being managed, the risks involved and whether staff had the necessary knowledge and skills to respond to these needs. For example in the person care plan for their diabetes, it only stated person "Has Type 2 diabetes. Person has no sugary food due to this' and there was no detail as to how the person's sugar levels would be monitored. For the person who had epilepsy, the care plan only stated "Risk of epilepsy where person loses consciousness, staff to monitor and ensure safety at all times" however there was no other guidance or protocol in place which detailed what action they should take if the person has a seizure and the need to call emergency services if needed.

We did see some daily records had been completed by staff which contained some information about peoples' support and what they had eaten. However the records were unstructured and unreadable at times.

During the inspection, the provider was unable to retrieve documentation promptly and took considerable time trying to locate information that we requested. Some of the information we requested, the provider was unable to find during the inspection. Staff working at the home were also not able to assist us as they were not aware and did not have access to any of the documents. The provider kept all the documents in an office which was locked.

The provider could not find the complaints record book and told us there have been none. However, there was no evidence that people are encouraged to feedback concerns and day to day complaints,

We spoke to the provider about this and she told us she was in the process of reviewing and updating records which is the reason why the records were in such a state.

Inadequate

Is the service responsive?

However the care plans did not reflect people's current needs correctly which put people at risk of receiving inconsistent care and not receiving the care and support they need. Complete and contemporaneous records had not been kept about people's care and support they needed. Risk assessments lacked detailed which could place people at risk of receiving inappropriate care which is not safe.

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

During the inspection, we found there were periods throughout the day where people were doing little and sitting around. There was little interaction from care workers who did not engage with people or involve them in meaningful conversation, daily living tasks or activities which reduced the quality of life experienced by people using the service

Care workers and the provider tended to be busier with chores around the home, putting Christmas decorations up and cooking meals and did not have the time to sit and spend quality time with people using the service. We noted that two people using the service were sat in the same position/seat for quite a long period of time, although a care worker did prompt for people to get up but they did not respond and remained seated. There was no further encouragement from staff to try and motivate the people who also have mobility needs to walk around and not remain inactive for long periods of time. This could also place people at risk of developing significant pressure sores. The radio was on in the lounge area and quite loud however there was no indication from people using the service that they were listening or enjoying the music,

There were instances in which a care worker did try and engage with one person with the Christmas decorations. On another occasion, the care worker gave the person a puzzle to do and told another person to read the newspaper however people did not engage and staff did not encourage people or sit with them to support them with the activity.

People's care plans contains limited information about people's interests and what they liked to do. We noted in one person's care plan, it stated they liked to play soft ball in groups, card games and loves reading and talking about planes. The person's care plan stated staff are to engage in these activities however during the inspection there was no attempt by staff to engage in these activities. In another person's care plan, it stated the person was very sociable and for staff to engage in 1-1 discussion and go through the person's photographs. The care plans also stated to encourage activities which help with mobility and memory. During the inspection, we saw no attempt being made to engage in such activities with the person although it was clearly stated in their care plan.

There was limited information about what activities people were involved with and information was not recorded on a regular basis and there were gaps. For example in one person's care plan, we only saw a few records which showed on the 5/3/15, their activity was going into the garden, on the 15/4/15 they went for a walk in the community. On the 4/7/15, they were engaged with relaxation, however it did not state what this relaxation was, on the 17/7/15, they were engaged with arts and crafts and watched TV on the 23/7/15.

Individual activity planners were not in place and records did not contain information about the activities people had been engaged with or plan to be engaged with during the week. Neither was there any evidence to demonstrate that activities were being monitored to ensure that the activities people were engaged with were meaningful or that they had taken place. Three people using the service are elderly who have mobility issues and may have dementia. There was no activities in place or recorded that would help them with their mobility and memory such as gentle exercises or something that involved some movement and pictures or objects of reference that would help them to remember and reminisce about times that were important to them.

For one person using the service, it specifically stated in their care plan that there were 'Risks of having unstructured days with no meaningful activity due to alcoholism' however during the inspection, we observed there was no structure in place for their day and the person was not involved in any meaningful activity or engagement and spent most of their time in their room.

People were not receiving person centred care that was appropriate to their needs. People using the service were not in engaged in meaningful activities.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

The service was not well led and poorly managed. The management structure of the home consisted of the provider and a team of care worker including two volunteers. Despite having staff, during the inspection, we observed the provider was carrying out numerous tasks including a significant range of care tasks. The provider was providing people with personal care, cooking, taking phone calls and attending to visitors. There was no evidence of delegation to the care workers who were unable to carry out their duties without constant instruction by the provider. It was not evident that the provider gave recognition towards care workers skills and qualifications as some of the care workers had NVQs in health and social care and did not seem to be actively supported to take on more responsibilities around the home. Records also indicated care workers were not receiving the support for personal development in their roles, skills and knowledge.

The provider is also responsible for drawing up people's care plans, risk assessments, training, supervision and appraisals for staff, recruitment, review of records and liaising with the appropriate healthcare professionals. Apart from the daily records, there was no evidence to show that staff were involved with any of the paperwork which meant records were not comprehensive, up to date and not easily accessible.

We saw some evidence which showed checks of the service were being carried out and this was also done by the provider. Checks covered the premises, health and safety and care plans. However some of the checks were not clear and once again not recorded consistently. For example records for the fridge temperature showed the fridge temperature as10oc which is outside of the safe temperature range and the fridge and freezer records were not clear as some records were measured in Fahrenheit and some in Celsius. There was a record of a safety check done by an external agency which stated the service to 'Ensure all staff have been trained in food safety' however staff had not been trained yet in food safety but records showed that this training was 'pending.'

Although some checks had been completed by the provider, the checks failed to identify the issues and concerns as raised during this inspection. These included the lack of support and development of staff to enable them to support people effectively, to ensure the service responded to people's individual needs and that people had the opportunity to be engaged with meaningful activities and develop their daily living skills. Care workers performance had not been assessed to ensure they were competent enough to carry out their roles. The care and support being provided to people using the service was task focused which meant care workers were more focused on household chores and tasks relating to their work rather than spending quality time with people, engaging and involving them in meaningful conversation and activities.

Checks also did not identify that people's care plans were not person centred and did not reflect their current needs/ preferences. All risks to people had not been identified and managed appropriately. Complete and contemporaneous records had not been kept about people's care and support they needed

During the inspection, the provider was unable to show us what the arrangements were in place to gain feedback from people using the service and relatives and any areas of improvement had been actioned. One relative told us they were not asked for feedback about the service.

This demonstrated the current systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not provide care and treatment to people that was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's mental capacity to consent to care and treatment had not been appropriately assessed. The provider and care workers had limited understanding of the implementation of the Mental Capacity Act 2005 (MCA). Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The assessment of risks to the health and safety of people using the service was not being done appropriately. Regulation 12 (1)

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

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Care workers were not supported to have the necessary knowledge and skills they needed to carry out their roles and responsibilities Regulation 18 (2) (a)
	The provider failed to maintain an accurate, complete and contemporaneous record in respect of the care and treatment provided to people using the service. The current systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people. Regulation 17(1) (2) (a) (b) (c) (f)