Rooks (Care Homes) Limited

Green Hill

Inspection report

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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?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

Green Hill Care Home provides accommodation for up to 30 people who were living with a dementia type illness and who needed support with their personal care. The home has undergone extensive modernisation building over the past two years. The extension was to provide additional ensuite bedrooms, a sensory room, bar and café and small shops to encourage independence. Accommodation is arranged over two floors and there is a lift to assist people to get to the upper floor. The home has 30 single bedrooms. There were 22 people living at the home at the time of our inspection.

The inspection took place on the 10 and 13 November 2014. We also inspected on the 3 December 2014 in response to concerns raised. There was a registered manager at the home. '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 and associated Regulations about how the service is run.'

Summary of findings

We last inspected Green Hill on the 01 August 2013. At that inspection we found the provider was meeting all the essential standards that we assessed. However at this inspection we found a number of areas of concern.

Although people told us that they felt safe in this home, there were times when there were not enough staff to meet people's needs. This impacted on the support that people were provided with at meal times and on the discrete supervision that was required to keep people safe. One meal time was disorganised and people did not receive support at the time they needed it. People left their food uneaten. Equipment and some parts of the accommodation were not maintained to a clean and hygienic standard and areas of the home had an unpleasant odour. The quality monitoring processes were not effective as they had not ensured that people received safe care that met their specific needs. The systems used by the provider to assess the quality of the home had not identified the issues that we found during the inspection.

People told us that they, and their families, had been included in planning and agreeing to the care provided. People had an individual plan, detailing the support they needed and how they wanted this to be provided. However people did not always receive support in the way they needed it. We found that some people's support was not provided as detailed in their care plans and some people's changing needs were not accurately reflected.

The home had not taken into account people's abilities to make decisions for themselves. Whilst people at Green Hill lived with dementia, some people were able to share their wishes and preferences about day to day choices. Staff were not following the requirements of the Mental Capacity Act 2005 (MCA). Nor had they taken action to review care delivery and support with regards to the Deprivation of Liberty Safeguards (DoLS) for people whose liberty may be being restricted. The MCA and DoLS are regulations that have to be followed to ensure that people who cannot make decisions for themselves are protected. They also ensure that people are not having their freedom restricted or deprived.

Staff training had not been provided. The training programme identified that medication training, safeguarding adults at risk, moving and handling and infection control had not been undertaken for up to two years. There was evidence that other learning was not always put into practice. The provider did not have a system to assess staffing levels and make changes when people's needs changed. There were times when people had not had their individual needs met as the staffing levels were not sufficient. Therefore they could not be sure that there were enough qualified staff to meet people's needs.

People had meals, snacks and drinks, which they told us they enjoyed. We were told that some people had had been involved in planning menus. Food was returned uneaten at lunch time and no alternatives offered. Records for food and drink not eaten were not kept. This had not ensured people received enough food and drink to maintain a balanced diet.

There was a system to receive and handle complaints or concerns. However not all had been dealt with in line with their complaint policy and procedure.

There were some positive aspects of care at the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported as much as possible to maintain their independence and control over their lives.

People were treated with kindness and patience. The staff in the home spoke with the people they were supporting in a respectful manner. There were some positive interactions and people enjoyed talking to the staff in the home.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. All the visitors we spoke with told us they were made welcome by the staff in the home.

The provider used safe systems for the recruitment of new staff.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the number of suitably qualified and experienced staff during the day, in protecting people by maintaining the home to a safe, clean and hygienic standard and not monitoring the quality of the home well enough.

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

Inadequate

The service was not safe. People were being put at risk because cleanliness and hygiene standards had not been maintained.

Risk assessments that informed safe care delivery were not always up to date and did not reflect people's changing needs.

There were not enough suitably experienced or qualified staff on duty to meet people's needs consistently and safely. Poor moving and handling and medication administration practices were observed. Staff training in managing challenging behaviour had not been provided to meet people's identified needs.

Senior staff had not identified potential safeguards and had not reported incidents that placed people at risk.

There were robust recruitment procedures undertaken before staff started employment at Green Hill.

Is the service effective?

Inadequate

The service was not effective. People's rights were not protected because the Mental Capacity Act 2005 Code of Practice and the Deprivation of Liberty Safeguards were not followed when decisions were made on their behalf.

Although people received enough to eat, the meal time was not well organised and some people did not receive the support they needed to eat their meal.

Whilst staff had had some training and supervision, it had not been regular or put into practice to ensure people received care which was based on best practice.

People told us they felt involved in how their care was given, and that staff understood who they were and what they liked. Feedback from visiting health professionals was positive about the staff.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were positive about the care they received, but this was not supported by some of our observations. Care mainly focused on getting the job done and did not take account of people's individual health and social needs and did not always respect or maintain people's dignity. People who were quiet received very little attention at busy times.

Visitors told us that their relatives were well cared for and we observed that the staff were caring and people were treated in a kind and compassionate way when approached. The staff were friendly, patient and discreet when providing support to people.

Summary of findings

People told us that they could have friends and relatives visit whenever they wanted. They also told us they could have privacy if they wished. People felt that staff treated them with respect.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Care plans were clear, written in a person specific way and evidenced regular review. However not all reflected changing needs and therefore people did not always receive support in the way they needed it.

There was a system to receive and handle complaints or concerns. However not all had been dealt with in line with their complaint policy and procedure.

There were not enough meaningful activities for people to participate in to meet their social needs; so some people living at the home felt isolated and bored.

Visitors told us they felt comfortable giving feedback to the staff about the care their relative received.

Is the service well-led?

Inadequate

The service was not well-led. Although there were systems to assess the quality of the service provided in the home we found that these were not effective. The systems used had not ensured that people were protected against the risk of infection or of receiving inappropriate or unsafe care and support. There were no satisfaction surveys sent out to gain people's views on the service delivery, or how they could improve.

The home had a vision and values statement, however this was not displayed and staff were not clear on the homes direction. Staff told us that they did not feel supported by the management.

There were no records that identified people, their families or staff had been consulted about the running of the home.

There was a registered manager in post.

Green Hill

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 unannounced inspection took place on the 10 and 13 November 2014 and additionally on 3 December 2014 following new concerns raised. We spoke with 11 people who lived at Green Hill, three relatives, the registered manager, seven care staff, and the cook. We observed care and support in communal areas and also looked at the kitchen and 20 people's bedrooms. We reviewed a range of records about people's care and how the home was managed. These included the care plans for seven people, the staff training and induction records for all staff, seven people's medication records and the quality assurance audits that were available. Not everyone we met was able to tell us their experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

The inspection team consisted of two inspectors. Before our inspection, we reviewed the information we held about the home. This included complaints and concerns, notifications of deaths, incidents and accidents that the provider is required to send us by law. We contacted the commissioners of the service and two healthcare professionals from the local GP surgery, a GP and a community psychiatric nurse. We also had feedback from the social services placement team.

Inadequate

Is the service safe?

Our findings

People were not safe because they were not protected against the risk of infection and there were not enough staff to provide the support people needed.

Staff in the home had not taken action to ensure people were provided with a clean and hygienic environment to live in. We found significant problems with the cleanliness and hygiene of the home. Toilets and accessories were unclean and unhygienic with unpleasant odours. When we returned to the toilet following the scheduled cleaning before lunch, there had been no change and staff were continuing to assist people to use this bathroom. We identified this to the registered manager and they were cleaned. There were also unpleasant odours in certain bedrooms and the communal areas which did not improve throughout the day despite the cleaner working in the home. The laundry room had an industrial washing machine which had recently been repaired but was again not working. A second domestic washing machine was being used but did not have the same sluicing and heat cycles required for soiled linen/clothes. Therefore the linen may not have been cleaned to an adequate standard to prevent cross infection. Commodes were rusty and therefore permeable to bodily fluids. This would make it difficult to clean them to a hygienic standard. In one bathroom we noted that staff cleaned used commodes in the bath, and cleaning mop heads had been left in dirty water. This bathroom was open to people to use the facility. There was no daily cleaning schedule or check list completed. These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who could tell us their views said that there were enough staff to provide the support they needed. One person told us, "There are always staff about", and a visitor to the home said, "If I was being critical, then they need more staff, however, they try hard." Staff we spoke with said there were enough staff to provide people with the basic support they needed and to keep people safe, but there wasn't time to just sit and chat or take them out in to the garden. Our observations showed there were not enough staff to meet peoples social and welfare needs.

Many people in the home were mobile. Staff were not able to monitor the whereabouts of people who were at risk of falls. We found one person had had an witnessed fall. They had managed to leave the ground floor communal areas without staff being aware. An inspector called for staff to assist this person who was unharmed. Another person had managed to access the courtyard without staff being aware. Staff said, "It can be a bit pushed at times." Another member of staff said, "We need more staff because our residents are mostly very mobile and some are challenging." At our inspection on the 3 December 2014 we looked at the past three weeks rota which identified that there had been an occasion that only two people were on duty for the 12 hour day shift. One staff member brought this to our attention as they had been on duty and had felt unsafe. This left people at risk from falls and receiving inadequate care as staff could not meet their needs. The provider had not used a dependency tool to determine safe staffing levels for people's health, social and welfare needs to be met.

We looked at incidents and accident records. We saw that there was evidence of altercations between people that had resulted in harm. These had not always been witnessed in time to prevent harm or for staff to deescalate the situation safely. There were a not enough staff to provide people with the support they needed at the time they needed it; and there were not enough staff to check that people who were eating in other parts of the communal areas ate enough food to maintain their health. These issues were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risk assessments for people's health and the environment had been undertaken on admission and reviewed regularly. However we found that not all reflected people's changing needs and variable needs. Incidents between people had occurred but were not reflected in people's care plans.

We observed poor moving and handling practices. One person was lifted up from the floor to a standing position by staff. This put both staff and the person at risk from injury. We saw another person being supported to walk with a transfer belt and two staff. A transfer belt should be used for assisting a person from chair to wheelchair. We observed that staff used the transfer belt to walk a person from the lounge to the toilet. The home had a stand aid hoist but this was not charged and ready for use. The manager told us that people's mobility was varied depending on how they were on the day. Staff said "On a bad day there are people who cannot stand on their own."

Inadequate

Is the service safe?

The risk assessments for people did not reflect alternative safe moving and techniques for people when they were having a 'bad day.' For example one person had been up all night so was very sleepy and uncooperative and we saw them curled up in a chair all day. We were told that this person could usually walk, but they were having to lift and fully assist manually on the day of the inspection. This raised concerns because there was no full hoist in the home. This had not promoted this person's safety. One person had been physically assaulted by another person, but this had not been reflected in their personal risk assessments as how to keep this person safe. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

The provider had appropriate arrangements in place for the safe receipt and disposal of medicines. There were records of medicines received, disposed of, and administered. Clear medication policies to guide staff were available. However as stated above the policies were not being followed in practice. We looked at nine people's MAR charts and found that the recording was accurate and clear. Staff told us that people were currently taking their medication as prescribed. Skin creams were recorded by care staff on a separate recording sheet. This assured us that the records showed people were given their medicines as prescribed. Medicine administration audits were conducted on a monthly basis. Any anomalies recorded were followed up by senior staff, such as when staff signatures were missing. Despite the arrangements put in place by the provider for the management of medicines, we saw poor practice in the administration of medicines.

We observed the midday medication being administered. We saw that the trolley was left open and unattended with medication left on top whilst the staff member administered medicine to people in the communal areas. People were walking around the trolley and could have taken medication detrimental to their health. The medication administration record (MAR) charts were signed before the person had taken the medication. Medicines therefore had not been administered in line with the home's policies and procedures. These practices observed had not ensured people's safety.

The staff training plan and observed care practices showed that staff had not received the training or refreshers necessary to meet the needs of the people currently living in the home safely. We saw that staff had not received medication training for two years and medicine competency assessments had not been undertaken. This lack of training was evident during the medication round. Staff were in need of updating their infection control training, moving and handling and food hygiene. One member of staff told us that they had yet to receive any training despite being employed for six months. Staff told us they were unsure of when specific training had been undertaken, but were sure they had had some. Staff files could not confirm staff had had training or refresher training. The lack of training in safe moving and handling, safeguarding of adults at risk, medication administration and infection control placed people at risk from inappropriate treatment. These issues were a breach of Regulation 23 of the Health and Social Care Act 2008.

We could not confirm that all staff working at Green Hill Care Home had completed safeguarding adults at risk training due to the lack of up to date training records. Staff were able to tell us how they would respond to allegations or incidents of abuse, but we saw recent incident records that should have been referred to safeguarding and hadn't been. Therefore these people were still at risk. We asked that these were referred to social services as matter of urgency.

At our inspection on the 3 December 2014 we looked at the heating arrangements in the home. Five people had extra heaters in their room to use if they were feeling cold and we were told it was their choice. We could not evidence that these heaters were tested, safe and individually risk assessed for those people as there was no supporting documentation in place. The mini heaters could be a risk hazard for two people as they were mobile and living with dementia. In the dining area and corridor we saw that new radiators had been installed, but the hot pipes had been left exposed. They were hot to touch and could cause heat damage to frail skin. This was pointed out immediately for action. We could not be assured that the systems for heating the home were safe and effective because windows had been left open, hot pipes were uncovered and portable heaters were used in areas that might be a trip hazard.

Robust recruitment processes were followed. Files contained a completed application which included the

Inadequate

Is the service safe?

work history, qualifications and experience of the person applying for the job. There were two references and criminal record checks requested, and received, before the provider employed the person to work at the home.

Inadequate

Is the service effective?

Our findings

People gave us complimentary comments about the service they received. People felt happy and well looked after. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us. People told us, "They look after us well, we see the doctor as well," and "I get looked after." A visitor said, "My mother is looked after here, we spend all day with her and feel that they understand her well, they tell us when the doctors been and any changes." We spoke with a district nurse, who was happy to share her views on Green Hill. She said, "Good standard of care, staff always helpful and ask for advice when they need it. Staff are keen to learn and want to learn. Definite team approach."

People's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. However the care plans lacked detail to provide person specific care for their individual needs. For example, care plans identified when a person was incontinent, but there was no guidance for staff in promoting continence such as taking to the toilet on waking -or prompting to use the bathroom throughout the day. There was no information of how often personal care in relation to continence should be provided. Throughout our inspection we identified that continence management was a concern. Another example was managing people's challenging behaviour. For one person there had been a number of recorded incidents of inappropriate sexual behaviour and aggression between people. The care plan did not explore how to manage this or a plan of prevention. We found there was no guidance for staff in managing situations before they escalated.

Some people who lived at the home had bed rails. Under the Mental Capacity Act (MCA) 2005 Code of Practice, the use of bed rails could be seen as restraint. Bed rail risk assessments were in place for all people where bed rails were used but no clear rationale recorded as to the reasons they were required. For people who could not consent to the use of bed rails, the home had not completed mental capacity assessments or referred as a Deprivation of Liberty Safeguard (DoLS) to the DoLS safeguards team. Bed rails were not used in a people's best interest and in line with legal requirements.

People were restricted to the home. The communal areas were accessible to people whilst other areas, such as bedrooms and grounds were accessible only by a key fob held by staff. This prevented people from leaving the communal areas and the home. There was no free access to the garden areas without staff supervision. There were people who wanted to go out to the village and this was not routinely provided or offered. For some people we saw that tables were placed in front of them which restricted their movement. One person had left the home unnoticed by staff three times and there had not been a DoLS raised. There had been no plan of support devised to meet this person's needs. The manager told us that one of the directors would include this person in raking leaves and tidying up the garden but this was not recorded.

The staff we spoke with demonstrated a lack of clear understanding of the MCA and of DoLS and how this affected people in the home. We saw that staff had not received training in the MCA or in DoLS. The new guidance that has been supplied to all health care establishments was not fully understood by staff at Green Hill Care Home. This was a breach of Regulation 18 of the Health and Social Care Act 2008.

Staff told us that they had not received training recently and records showed that essential training such as infection control had not been provided. Staff had not received regular supervision. For some staff there were gaps of up to one year since their last supervision. Staff had not received medication competency assessments. We could not be assured that there were sufficient staff working at Green Hill Care Home that had received the training and support necessary to meet people's needs. This was a breach of Regulation 22 of the Health and social Care act 2008.

People told us that they enjoyed the meals provided, however although the staff were kind and tried to provide the support people needed, some people did not receive the help they required to eat their meals. There were two staff supporting people to eat, one of whom tried to assist two people at once, which meant neither person received the support they needed. One person tried to eat unaided, but was unable to and got up and walked away. This person did not return to eat their meal and therefore did not receive the necessary nutrition at this time. We observed that the staff members who were supporting people to eat had to leave the individuals they were

assisting to go and help other people. People's meals were therefore interrupted, and two individuals who needed support did not get it properly. The meal service observed was rushed and not an enjoyable experience.

There was a choice of two main meals and we were told if people did not want either of the main meals offered, they could choose an alternative. However an alternative was not offered until we intervened and asked for them. People told us that they liked the food and said that they were given a choice of meal. One person said, "The meals are nice, there's a bit of choice" and another person said, "The food is good". We noted on one day that sandwiches were offered at 4pm and then again sandwiches at 6pm which indicated a lack of choice. The menu advertised was not being followed on the day of our inspection.

During our inspection people were provided with enough to eat and drink. People were offered breakfast, lunch, afternoon tea at 4pm, and then a light supper at 6 pm. Visitors told us that people 'seem to get enough to eat.' Staff however did not monitor refusals or follow up partially eaten meals. People were not offered an alternative by staff when they stated they didn't want to eat the food or had left their food. Weight recordings were not consistent (some months had been missed) and one person's weight loss had not been followed up for two months which had impacted on their overall health, which was now improving.

The cook told us that some people had been involved in planning the menus. They had identified meals on the menu they enjoyed and if there were any meals that they did not like these were removed. The cook told us that there were people that required special meals, such as soft (forkable), diabetic and pescetarian. We received negative comments about the quality of food, "Quality of food has recently gone down." The food provided was presented was nutritious but not much thought had been taken with the presentation of the soft diet or the way staff presented food to people. Staff told us, "The cook does really well, today though it's a bit rushed because the cook is going off early," and "Its okay I think, people enjoy it but it is basic."

External health care professionals had visited the home, such as GP's, speech and language therapists, chiropodists, opticians and the district nurse. The staff recorded health professional visits in individual care plans. People were happy with the health care support they received. One person told us, "We have a chiropodist and optician, I think they come and visit every so often. The dentist and GP visit as well."

At our inspection on the 3 December 2014 we looked at the heating arrangements in the home. The home was heated in three separate zones. The thermostat was set to 30 degrees Celsius and came on at set times, 5am until 10 am, 12 until 2 pm and 5 pm until 9:30 pm. The communal areas of the home were warm. A small portable heater was in use in the quiet lounge. This was because the radiator whilst working was not efficiently heating the room, a new radiator had been ordered. The maintenance records and provider confirmed this. We spoke with staff and visitors about the heating. Staff told us that they found the home gets really warm. One staff member said, Too hot sometimes." Whilst another said, "I was chilly earlier." Three visitors said, "I have never known it to be cold here." Another visitor said, "My granddad's room is sometimes chilly." Later on this visitor told staff his room was cold and they could not sit it in. The room was checked and found cold and the radiator had been turned off. Staff had not checked that this room was warm enough for people to spend time in.

We walked around the all parts of the home. One corridor of bedrooms on the first floor was cold and we found bedroom windows throughout the home open at 4pm. Staff said, "We air all the rooms when people get up but someone must have forgotten to close them, they should be closed by lunchtime." We visited three people in their rooms and they were warm and cosy.

Requires Improvement

Is the service caring?

Our findings

We identified aspects of care that impacted on people's dignity. However people and their relatives stated they were satisfied with the care and support they received. One person said, "Really caring." Comments from two visitors and the district nurse told us that they were impressed with the caring and kind staff at Green Hill. "Very attentive and patient staff," "They are so kind here," and "They treat my mother with respect."

People's dignity was not being promoted as people's clothing was not changed despite being soiled. Napkins and clothing protectors were not offered during meals and clothes that were stained following meals were not changed. There were people whose continence needs had not been met pro-actively, which meant that there was strong odours apparent from both communal areas and from specific people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said that staff respected their privacy. One person said, "The staff help me wash in my room, I always feel my privacy is respected." This person was able to give us an example of what staff had done to ease their embarrassment in relation to personal care. The district nurse told us that staff always ensured that people were treated in the privacy of their bedroom and people were always dressed appropriately. A relative told us, "When we visit, we see that staff take people away from the communal area if there is a need to attend to them."

People were dressed in clothing that was appropriate to the weather and as far as possible their own choice. One staff member said, "They can't always choose their own clothes but when I am here, I make sure their clothes match and are not scruffy, they deserve to look nice. Some of the ladies are really particular about their hair and like to wear jewellery." One person was dressed in outdoor clothes and that was their preference.

The care plans showed that family and person involvement had been sought where possible, and each person's care plan included a life history and family tree. We saw that personal preferences had been recorded on admission to the home and where possible set out people's preferences for daily life and for when they reached the end of their life. One care plan detailed that the person liked to sing along to old songs and staff said that they encouraged them to sing in their bedroom. The registered manager told us that one person who lived in the home had an advocate. They also told us they had information to give to people and families about how they could find one if it became necessary. This ensured people were aware of advocacy services which were available to them.

Staff were knowledgeable about the individual personalities of the people they cared for and supported. Staff shared people's personalities with us during the inspection and they talked of people with respect and affection. One care staff member said, "The residents are lovely and they come first." Another said, "It's been unsettled here recently with staff leaving, but I stay for the residents, It's not always easy here, but we give our best."

We observed some really kind care delivery by staff, for example, one person was feeling lost and a staff member gently reminded them of where they were and assisted them to the bathroom, chatting away together. This person was treated with empathy by the staff member. Another person was feeling upset, a staff member sat down alongside them, gently reassuring them until they were calm again.

Relatives and friends were able to visit at any time One relative described the staff as "Always very friendly, welcoming and compassionate."

Requires Improvement

Is the service responsive?

Our findings

We asked people and their relatives if they had been involved in choosing how they were supported and cared for. One visitor said the staff kept her up to date with her mother's care but did not feel totally involved. Care plans we looked at were well organised with an index at the front. This made it easy to find where information was in the file. The files gave information about the person's family history, their preferences, relationships, family and key medical information which gave staff an understanding of the people they cared for. However the care plans had not been updated to reflect changes in people's health and social well-being.

Staff told us they felt the care plans were clear and guided them in to looking after people properly. Staff were seen to refer to people by their preferred name, and show an interest in them and what they were doing. Care plans had been written in a person specific way and had been regularly reviewed. However some lacked detail of how to meet a person's changing needs. For example one person was getting frailer, both mentally and physically and this was not evident in the reviews. The care plan review stated no change, but when we talked to staff they mentioned the person slept more and was not engaging in conversations as they used to. There had been no amendment made that indicated a need for one to one time to prevent isolation or that changes were needed to their mobility care plan. In another care plan there was no mention of recent behavioural changes and mood swings. This meant that new staff would not be able to provide care in the way that was now required. This was an area that required improvement.

We looked at people's individual care plans to see if people's wishes were reflected and acted on. The care plans did not fully reflect some people's specific need for stimulation. There were times when we saw that people were isolated and staff interaction was minimal due to other tasks being undertaken. Activities were not as yet meeting people's individual interests and hobbies. However one staff member showed us the new activity book that she was creating. This book was a reflection of people's individual preferences and of their interests, both past and present. It highlighted activities to be introduced that met peoples wishes. This book had been created whilst working with people so reflected their capabilities. A sensory room was available but as it was not yet completed it was being used as a cinema room. This was used for films during our inspection, but not for any other reason but to stop someone from asking to go out. The manager had also built a bar and café area, with shops that people could buy toiletries and sweets. The plan was to use these areas to provide stimulation and promote independence. However these were not being used and we observed people were bored with little to occupy or distract them. People were not encouraged to participate in any form of activity or make use of the environment.

People told us that there were activities on offer sometimes, but these did not happen very often. One person told us, "We have had a singer that came in, and we enjoyed singing along with them." However another person said they were, "As bored as could be, I want to go out to the village, but I can't go on my own." A relative told us, "It depends on who is on duty really and on how people are, my mother sometimes likes to participate but not always, I have seen a staff member doing nails and talking with them though." Another relative told us "Someone did ask us what hobbies my relative enjoyed."

Whilst visitors were welcomed during the day and there were some activities on offer by the provider there was a need to give more stimulation and individual activities to people over the course of the day. This was an area that requires improvement.

We asked people what they would do if they were unhappy with the home. They all told us they would tell the staff. One person told us, "I would tell the staff." Another said, "Complain, I have no complaints." A relative said, "I would talk to the staff, but I am aware of the complaint process if I wanted to make a complaint." Another relative told us they had seen the complaint procedure in the welcome pack.

The staff kept a complaints log. We saw that a record was kept of each complaint that had been received. The provider had recorded the investigation into the complaints and identified any trends, patterns and contributory factors. Whilst records told us that complaints had been responded to in good time, we received information from an ombudsman who said that the response from the manager had not been good or pro-active. The ombudsman had investigated on behalf of a complainant and had taken the relevant action through their processes. We spoke to the provider who told us that they had responded to the ombudsman and had not

Requires Improvement

Is the service responsive?

received any further communication but had not followed up on recommendations made. The complaint was also known to placement team of social services. At this time we could not be assured that the complaint had been fully resolved. We recommend that the provider review their complaint processes to ensure that all complaints are responded to within a time scale and fully resolved.

Visitors told us they felt comfortable giving feedback to the staff about their care. We asked people if they thought things improved if they raised issues with the provider. One relative told us, “I would tell the staff and they would try hard to resolve it.”

Inadequate

Is the service well-led?

Our findings

The provider did not have effective systems in place to monitor the quality of care provided. Although there were systems to assess the quality of the service provided in the home we found that these were not effective. The systems had not ensured that people were protected against some key risks relating to inappropriate or unsafe care and support. We found problems in relation to lack of hygiene, odours throughout the home, staffing levels, and the assessment and meeting of people's needs in relation to equipment and lack of staff training.

The provider had a vision and values statement, however this was not displayed and staff were not clear about the home's direction. There was a registered manager in post however she also managed another home in Kent and therefore was not always available. Staff told us that they did not feel supported by the management. One staff member said, "I do not see the manager on the floor very often, they are not usually around." Another staff member told us, "I do not feel supported by the management." One staff member told us, "The communication from the manager to staff is really poor, we don't know what's going on with the home a lot of the time." There were no records which identified team meetings had taken place. One staff member told us, "I can't remember when we last had a team meeting."

Staff files identified that formal supervision meetings did not taken place regularly. Records identified that some staff had received supervision in October 2014; however these had not been signed as accurate by the staff members concerned.

The provider did not have appropriate systems in place to record staff training. The staff training plan was not up-to-date. We looked at individual training certificates within staff files, these identified that staff had attended recent short courses that had not been added to the training plan. However front observation the training was not being put in to practice to meet people's needs.

There were no records that demonstrated that people, their families or staff had been consulted about the running of the home. There were no other systems in place for staff to discuss issues and influence the operation of the home. All the issues above were a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had failed to provide staff with adequate guidance and support in relation to best practice when supporting people with behaviours which challenge. Staff told us, "I have been slapped and scratched by residents." This staff member had not received recent training on how best to support people with behaviours which challenge. Another staff member told us, "We have needed to call on the manager's husband for support when residents have been aggressive in the past." The manager's husband had not undertaken training for challenging behaviour. This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Accidents and incidents were appropriately recorded and formed part of the quality assurance systems that were in place. However the manager had not informed the appropriate agencies when they were required to. We saw that there had been incidents of abuse by one person to another person in the home. These should have been referred as a safeguarding referral for a multi-agency approach to ensure people's safety. Expert advice to manage the incidents and to prevent a re-occurrence had not been sought. This had not ensured people's safety and placed them at risk from emotional and physical harm. This was a breach of Regulation 18 (2) (e) Health and Social Care Act 2008 (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The planning and delivery of care did not meet the individual needs and ensure the welfare and safety of people who used the service. Regulation 9 (1) (b) (i) (ii) (iii) (iv)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of service users and others. Regulation 10 (1) (a) (c) (i) (d) (i) (e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained. Regulation 12 (1)(a)(b)(c) (2)(c)(i)(ii)(iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs

This section is primarily information for the provider

Action we have told the provider to take

	The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration. Regulation 14 (1) (a) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had not ensured Service user's dignity was promoted. Regulation 17 (1) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not have suitable systems in place to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experiences persons employed to meet the needs of the service users. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not ensured that staff had received appropriate training to meet service user's needs in respect of challenging behaviour. Regulation 23 (a)