

Miss G Patton

# Drakelow House Residential Home

## Inspection report

64 Parsonage Road  
Heaton Moor  
Stockport  
Greater Manchester  
SK4 4JR

Tel: 01614324033

Date of inspection visit:  
14 July 2016

Date of publication:  
09 May 2019

## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Requires Improvement** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Inadequate** 

# Summary of findings

## Overall summary

The unannounced inspection took place on 14 July 2016. We last inspected Drakelow House in June 2014 when we found the service was meeting the regulations that we inspected.

Drakelow House provides residential care for up to 18 people, some of whom are living with early onset dementia. At the time of our inspection there were 16 people living at the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager/owner had been involved with the service for over 20 years and was also known as the provider.

People told us they felt safe living at the service and relatives felt the same, however, we found areas of concern with regard to the safety of the building. Actions which needed to be finalised from a legionella and fire risk assessment which had been unduly delayed and not completed in a timely manner.

We found the cellar area of the service which was regularly used to be in need of repair and also posed an infection control risk to people. In this area we also found people's archived records to be stored in an unsecure way.

Staff had been recruited safely, but the provider had not ensured that they continued to be supported and developed as there was a lack of supervision and appraisal records and gaps in staff refresher training.

Levels of staff at the service were inadequate to meet people's needs. We found that the registered manager completed no dependency tool which would have assessed the level of staff required to meet the needs of people who lived at the service. Staff completed caring, cleaning, cooking and activity duties within their daily roles and this was not sustainable at current levels.

Activities were very limited for people who needed support with their social and psychological wellbeing as

there was no dedicated staff to complete this task.

The provider completed a number of quality assurance checks, however these had not uncovered some of the issues that we had found during the inspection and needed to be updated and improved. Although the registered manager/owner was well known and liked, we found that they had very little oversight of the management of the service and this was mostly dealt with by the deputy manager who was not registered with the Commission.

Staff at the service managed people's medicines safely and kept them stored in appropriate arrangements within one area of the service, but excess medicines were not stored in suitable conditions and we have asked the provider to address this.

Staff were able to explain their safeguarding responsibilities and there were procedures in place to support them, should they need to contact professionals in relation to this.

Emergency procedures were in place and monitored by staff at the service and accidents and incidents were recorded and checked for any learning to try and ensure the same accident did not happen again.

The living areas of the service were clean and tidy and the garden was well maintained with good stocks of established plants and shrubbery.

People enjoyed the food and refreshments that were prepared and staff helped those that needed support to ensure nutritional and hydration needs were met.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' it also ensures unlawful restrictions are not placed on people in care homes and hospitals. People's best interests' were taken into account. There had been no DoLS applications to the local authority but staff knew how to make them should the need arise.

People's health and wellbeing was monitored, with regular access to GP's and other specialist healthcare as the need arose. A nurse and GP we spoke with told us the staff were responsive to people's needs.

All of the people we talked with, and their relatives spoke highly of the staff and how well they cared for them. Relatives told us they always felt welcome. Staff had good relationships with people, they responded with a gentle and kind manner. Healthcare professionals thought that the staff were caring and would recommend the home.

Staff respected people's privacy. They knocked on the door and waited for permission before entering people's bedrooms and asked for consent before performing caring duties. They spoke to people with respect and addressed them how they preferred.

Care records reflected people's individual needs and were regularly reviewed to monitor for any changes. The provider was in the process of updating these to improve the layout and format.

There had been no complaints to the provider recorded. People and their relatives told us they knew how to complain and would be able to if they thought there was a need. People were able to make choices.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to Safe care and treatment, Person centred care, Staffing and Good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

People told us they felt safe at the home. However we found that actions had not been taken swiftly to rectify some areas in connection with risk assessments completed for legionella and fire safety. We found some issues with infection control which needed to be addressed.

Staff numbers were not adequate to complete all of the tasks they had to do and ensure people's needs were fully met.

Medicines were managed appropriately although storage in one area needed to be improved.

Staff were able to describe to us how they would respond to any concerns of a safeguarding nature.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

There were induction and training opportunities for staff and staff told us they were supported by their line manager, however we found that training was not fully up to date and records showed that staff had not received any appraisals and had limited formal supervisions.

Senior staff had an understanding of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005.

A range of suitable food and refreshments were available throughout the day and people were supported to eat and drink where necessary.

**Requires Improvement** ●

### Is the service caring?

The service was caring

Staff and people enjoyed positive relationships with one another and people spoke kindly of all the staff at the service.

**Good** ●

People were involved in their care and their privacy, dignity and independence was promoted.

### **Is the service responsive?**

The service was not always responsive.

There was little evidence of a range of suitable activities tailored to people to ensure their continued wellbeing.

Care records were detailed so staff could provide personalised care and support and these were in the process of being reviewed.

There was a complaints procedure in place and people knew how to complain.

People told us they were able to make choices about how their care was delivered.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not well led.

The registered manager/owner had little oversight of the service although people knew them and said they liked them.

Quality assurance checks were not robust and needed to be improved.

Staff told us that they enjoyed working at the service.

**Inadequate** ●

# Drakelow House 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 to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 July 2016 and was unannounced. The inspection was carried out by one inspector.

Prior to the site visit, we reviewed information we held about the service, including the notifications we had received from the provider about deaths and serious injuries. We contacted our CQC colleagues within the local area and were not made aware of any concerns regarding the service.

Before the inspection, the deputy manager had completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this to inform our inspection and support the planning.

On the day of our inspection we spoke with a visiting GP and a community nurse who was also visiting the service and used their comments to support the inspection process.

We spoke with 11 people who used the service and six family members. We also spoke with the deputy manager, one senior member of care staff and two care staff. We observed how staff interacted with people and looked at a range of care records which included the care and medicine records for six of the 16 people who used the service and staff personnel records for four staff members.

We placed posters on display within the service to let people and visitors know that we were inspecting. The posters also included contact numbers and who to get in touch with if they wanted to speak with us after the inspection in private.

We did not speak with the registered manager/owner on the site visit as they were not present at the service, although the deputy manager contacted them and informed them of our presence.

We looked at staff rotas, maintenance records, health and safety records and information, quality assurance checks, complaints and compliments and handover information.

During the inspection we asked the provider to send us some additional information. For example, a copy of their statement of purpose. They did this within the agreed timescales. A statement of purpose is a document setting out particular information, for example, how the service operates, its aims and objectives with important telephone numbers.

After the site visit, the registered manager/owner (also known as the provider) contacted us to confirm particular work was to be undertaken. We also contacted the infection control lead for the local authority 'Health Protection & Control of Infection Unit' and used their comments to further support the inspection process.





## Our findings

People we spoke with did not raise any personal safety issues, although one person commented that they thought one member of staff might not be enough cover to support the people who lived at the service overnight. We looked at the staffing ratio within the service on the day of the site inspection, over the course of the previous few weeks and also future cover arrangements.

We found that during the day, two staff were on duty from the hours of 8am until 9pm with one staff member covering the hours from 9pm until 8am. Additional sleep-in cover was supplied at night by the deputy manager who lived in the adjoining property.

The daily tasks of staff on duty covered their caring responsibilities and also cooking, cleaning, washing and ironing and activities within the service. The deputy, who was one of the two people on duty during the site visit, also had the additional responsibility of managerial tasks to complete. Although none of the people or their relatives complained about lack of staff, we found that this level of staffing was unacceptable. Staff did not complain about the level of work they had to do, but during observations we found staff were extremely busy at all times and going from one task to another without break.

We were told that one person needed support from two staff with their personal care needs. This meant that when one staff member was making meals, the other staff member was left to meet the needs of the 16 people who lived at the service. During meal times or if two people required support at the same time, or if the person who required two staff needed additional support; then either meal times or people's needs would be delayed. The same rationale applied to cleaning duties, washing and ironing and activities within the service.

The impact for people on the reduced staffing levels meant we saw people had to wait longer than would be classed as a reasonable time for particular tasks to be completed. For example, one person waited over 20 minutes to be supported to the toilet because one member of staff was busy with healthcare professionals and the other was busy with another person.

The cellar area in the service was used to wash people's laundry and was accessed via a steep, narrow staircase. Staff told us that they were not allowed to go into this area at night due to the risks of falling when there was only one staff member on duty. This meant that staff had to complete these tasks during the day when two staff were on duty, which meant that only one member of staff was left on the 'floor' to look after all 16 people who lived at the service. We found this level of staffing also had the potential to impact on

other areas within the service, for example, activities and meals which will be dealt with in the effective and responsive areas of this report. We also found there was more of a potential for accidents to occur, because staff were not always easily summoned and there was potential for those less mobile to risk 'being totally independent' when moving around the property and trying to do tasks for themselves.

We noted that the provider had been requested previously by the Commission to review their staffing ratios to ensure that people's needs were met. When asked, the deputy manager confirmed that no dependency tool was used to assess the number of staff required, and that staff levels were based on the knowledge of people by the registered manager/owner. We noted that one person who lived at the service required two staff members to support them with their moving and handling needs. We found that the level of perceived dependency was underestimated by the provider and no written assessment was undertaken. The registered manager/owner could not be assured that staff coverage was appropriate and therefore had not done all that was practicable to mitigate against the risk of not being able to meet people's dependency needs safely.

A legionella risk assessment had been completed at the beginning of the year and we saw that outstanding work had not been finalised. Including for example, two high level priority recommendations to increase the temperature of stored hot water and to cut off a number of unused water outlets. During the site visit, the deputy manager, organised a date for the following week for this to occur. We then received a message after the inspection to inform us that negotiations were taking place with regards the cost of this work. The contractor emailed us to confirm that the work had all been completed. This meant that the provider had not acted immediately upon knowing that there were high priority risks to people who lived at the service with regard to legionella disease and had only acted after our inspection had raised our concerns which put people at risk.

We saw that some of the checks on water and related equipment had not been completed and recorded since March 2016, including hot and cold outlet temperature checks, weekly flushing of the system and shower head sterilisation. This added to the risk we had found in relation to legionella control procedures.

When we visited the cellar area of the property, we found the area in need of some refurbishment and tidying. Three rooms were located down a narrow staircase. One room was used for laundry, one for a food store (dry and tinned), and the other for people's archived personal documents and other various miscellaneous items. Off the laundry room were another two rooms which were filled with various items. All, but the food store, had damp and mould growth on the walls and floors, and these areas were unclean. Staff told us it was difficult to clean the area due to damp, and the appearance of the area indicated it had been in this condition for some time.

We saw an infection control audit had been completed by the lead for care homes from the local authority in June 2016. They had found the laundry area to not have walls and floors that were readily cleanable, and had floors which were not sealed and impermeable. This meant that staff were working in unsuitable area and people's clothes were at risk of cross contamination from mould growths on walls as they were stored in close proximity. We later spoke with senior staff at the service who confirmed that work in the cellar area was to be completed when the builder returned from holiday in August. This meant that the risk remained for people and swift action had not been taken to mitigate this.

We found that a large storage cupboard in the kitchen area was used to store people's records and other information in connection with the running of the service, including policies and procedures and fire safety information. This meant that there was a further risk of cross contamination from staff using this area as an office and food hygiene levels were also at risk because food was prepared in this area.

As we walked around the service, we noticed in one particular toilet that the toilet stand aid was rusty and worn. This meant that this equipment could not be cleaned and needed to be replaced. We saw that the infection control audit completed by the lead from the local authority had also seen examples of this in other parts of the home during their visit in June 2016. This meant the provider had not actioned issues previously raised and there were continued risks to people regarding infection control issues.

When we visited the garden area, we noted that steps leading from a communal lounge did not have a hand rail in place for people to use when descending into the garden. One person told us, "I wish there was something to hold on to there [pointed to the steps]. I won't use them, as I am frightened of falling, and it's a shame, because the garden is lovely there." We communicated our findings with the deputy manager during the site visit and it was later confirmed that they had fitted a hand rail to provide additional safety measures for those using the steps.

We saw some windows on the upper level of the service had openings at the top section of the window. Risk assessments had not been completed to ensure that these areas were safe for people who lived at the service. These openings were not within easy reach of people, however, there was still potential for people to climb onto furniture and reach this area. We discussed this with the senior staff on duty at the time and later with the registered manager. We were informed immediately after the site visit that the openings had been secured on these windows and measures had been taken to ensure people were safe from potential of falls. This meant that at the time of the inspection, windows had no restrictors and had not been risk assessed to ensure they met current Health and Safety Executive (HSE) guidance, which potentially posed a serious risk to people living at the service.

Although day to day medicines were stored securely, we found that any excess boxes were stored in a room on the first floor of the service. This room was also used as an office which was used to hold staff records, and other management information. The door to the room was mostly made up of safety glass and did not have a good quality locking system. The medicines kept within the room were not stored separately in a secure locked cabinet, but on an open shelf. We contacted our pharmacy team and they confirmed that this storage arrangement was not adequate and that medicines needed to be stored as per best practice guidance.

As we have not yet returned to the service, we are unable to confirm if these actions have taken place and can only report on our findings on the day of the site inspection and what we have been told since.

These are all breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to safe care and treatment.

People told us they felt happy and safe living at Drakelow House. One person said, "Yes, I feel safe living here, why would I not. They are very caring these girls." Another person said, "I feel safe and well looked after." One relative told us, "I am very happy and content with how safe [person's name] is. I am not worried like I was before when [person] was living at home. I know she is safe in here." Another relative felt that their family member was safe and said, "No concerns with safety at all."

Staff had undertaken training in identifying and responding to safeguarding concerns. Staff we spoke with were able to describe the different types of abuse, and how they would respond if they had any concerns that people were at risk of abuse. All of the staff we spoke with told us they would report concerns to their line manager. This meant that people were protected from abuse and staff knew what to do if they had any concerns.

Accidents and incidents were monitored and analysed to determine if action could or should be taken to reduce the likelihood of them reoccurring, although we noted that the outcome of the accident was not always recorded on the accident form. The deputy manager confirmed that they would ensure details were recorded on the form in future. Action had been taken to reduce the risk of accidents reoccurring, for example we saw a referral had been made to one person's GP when they had fallen a number of times.

Risks that people were exposed to in their daily lives had been assessed and documentation was in place for staff to refer to about how to manage and mitigate these risks. These risk assessments were reviewed and amended when people's needs changed. We found from viewing care records people were routinely assessed against a range of potential risks, such as falls or in connection with moving and handling. We were not made aware of any general or individual risk assessments related to the use of stairs in the home. Staff told us that people rarely used the stairs and if they did it was usually with staff support, although there were times when these areas were not observed and people could potentially mount the stairs without support. This meant there was no clear assessment to ensure people could use the stairs safely. We recommend the registered manager undertakes risk assessments in relation to the use of open access stairs at the service.

Equipment checks were completed, including checks on fire apparatus. Emergency procedures were in place and documented what staff should do in a crisis. For example, if a fire occurred. The staff we spoke with were confident they knew what to do if an emergency arose and one was able to give us an example of how fire drills were conducted. We noted however, that from a fire risk assessment that had been completed, the actions had been delayed although were now concluded. We were told that fire drills occurred regularly, although they were not always recorded. We spoke with the fire and rescue service and brought to their attention our concerns regarding for example, staffing and the cellar area. They told us they now planned to carry out an inspection and would update us when completed.

As part of fire safety, staff had a "nominal role" in place. This document listed all people who lived at the service, their room number and any particular needs that they had which may have effected their safe evacuation in case of a fire. For example, poor eyesight or limited mobility needs. This showed that in the event of a fire staff would be able to access information which would enable them to support the safe evacuation of people from the service.

Other parts of the premises was clean and tidy with no odours with the garden area being well maintained and had lots of established plants. People and their relatives described the service as "homely". One person said, "This is my home now and I will end my days here...it's comfortable, pleasant and staff are good."

Staff told us and records confirmed that appropriate recruitment checks were carried out prior to staff starting work at the service and to help ensure that staff were suitable to work with vulnerable people. Two references had been obtained with face to face interviews held for applicants. Disclosure and Barring service checks (DBS) had been obtained and details were held on file. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups of people.

People told us they received their medicines on time and how they wanted them. People's medicines were safely managed and they received their medicines in a timely way and as prescribed by their GP. Apart from those previously mentioned medicines were stored safely in a medicines trolley and were locked away and secured to the wall when unattended in a trolley stored within the dining area. Discontinued medicines were safely returned to the dispensing pharmacy in a timely way. All medicines were competently administered by the staff in charge. One person looked after their own medicines and self-medicated. They had their medicines stored in a cabinet within their own bedroom and we saw that a medicines risk assessment had been completed to support them.

We noted that the service had the use of an out of date BNF book. The British National Formulary (BNF) is a pharmaceutical reference book that contains information and advice on prescribing medicines. We spoke with the deputy manager about this and they told us they would ask their pharmacy for a new copy.

People's personal finances were checked to ensure they matched with receipts and records kept, which they did.

### Our findings

There was a lack of evidence to confirm that staff supervision and yearly appraisals always took place. For example, one senior staff member had no written record of supervision or appraisal since 2012. A member of care staff had no supervision recorded after they started working at the service in 2015. We found no records of appraisal for any member of staff. One staff member said, "It's a small team here and I feel supported, I can talk to [deputy manager name] any time." Another staff member said, "I feel ok with the support, it's a good team here."

People were complimentary about the skills of staff. One person told us, "Oh yes, they know what they are doing." Relatives told us they felt staff had the training and skills to suitably support their family member with their care needs. All staff informed us that they felt equipped to carry out their roles and said they had completed various and suitable training to help them. The deputy manager provided us with information which showed that staff had completed training in a variety of necessary areas, such as food hygiene, fire awareness and infection control. We also saw that six out of eight senior carers and care staff had undertaken level two in a health and social care with four of the same staff having undertaken level three also. However, we saw that not all staff had completed the most up to date refresher training and some training was out of date. For example, there had been no recent update in safeguarding adults training, legionella training, mental capacity training and first aid training was out of date. This meant that although staff had received training, current best practice may not have been followed.

These were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to staffing.

Staff told us they went through an induction programme when they started working at the service, which included shadowing more experienced staff. One member of care staff said, "We had to do an induction when we started. It was good and helped you to get to know the residents better before you started working properly." The deputy manager was aware that the service had to incorporate the standards of the Care Certificate for any future employees. The Care Certificate was officially launched in April 2015. It aims to equip health and social care workers with the knowledge and skills which they need to provide safe, compassionate care. It replaces the National Minimum Training Standards and the Common Induction Standards.

We saw effective handover communication between staff taking place. This was both verbal and in written format. One staff member told us, "We always make sure that the staff coming on duty know what's been

going on, it's really important." Healthcare professionals that we spoke with thought that the communication within the home was very good. A district nurse said, "No problems. .... the staff are very effective in contacting us if they need any advice or if something is wrong. They would never just sit and do nothing." A visiting GP told us, "Yes, communication between the service and the surgery appears good and I am not aware of any issues there." Relatives also confirmed that communication within the home was timely and they were kept in touch with any changes or accidents that may have occurred in relation to their family member.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff were able to describe when best interest decisions had been made for people, although we were not always able to see evidence of this in records and staff were waiting to receive training in connection with MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Livery Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the principles and had not needed to make any referrals to the local authority to deprive anyone of their liberties. We spoke with the deputy manager about this and they were aware of who to contact should the need arise for advice.

People told us that staff asked for their permission before completing any personal care or support for them. One person told us, "They [staff] would not dream of just barging in and doing something without asking first. ...always very considerate." One relative told us, "I have overheard staff being very discreet with [person's name]. They [staff] always confirm that they [person] are happy before they do any personal care, which is exactly how it should be." This meant that the provider had instilled in staff the need to gain consent before embarking on any care or support with people.

People were mixed about their views of the food prepared and served to them. People told us that staff did their best and the food was either, "reasonable" or "ok" but "not as good as home cooked". Although we saw that most people ate all of the food on their plates during breakfast and lunchtime observations. Relatives told us that they thought the food looked "good". One relative told us, "It's always very difficult in places like this to keep everyone happy all the time. ....but the staff do their best to try to."

We asked what choice people had at lunch times and staff told us that there was a menu plan (which we saw) with one meal recorded; and this was offered. Staff told us and people confirmed, if they did not like the meal offering they could ask for something else. People also confirmed that larger hot meals were always provided at lunch time with usually smaller meals at night. One person said, "It's usually sandwiches or something like that at tea time, which is fine after our big meal at dinner time." We saw minutes from a meeting in 2015 where food had been discussed and new items for the menu had been suggested. People confirmed they now received these 'new suggested' items, for example, 'quiche' and 'lasagne'.

Where people required support to eat their meals, this was given. A member of staff told us, "Luckily, most people can support themselves with meals, but we do help some if it's needed." All of the people we spoke with did not know what they were going to be offered for lunch or tea. At the end of the inspection the deputy manager told us they were going to ask people on the day what they wanted to eat rather than the

day before. We confirmed this would help people to remember what was on the menu and make a more informed choice. Records we looked at showed us people had been weighed regularly by the staff, as part of monitoring their well-being and health and nutritional assessments had been carried out.

We noted that one staff member prepared the meals while another continued with caring responsibilities or other duties. On the day of the inspection and during lunch time preparation, staff were very busy, which included, taking calls to the service, speaking with families visiting, supporting visiting GP's and nurses and helping people with personal care. Throughout this period, and although we did not see any examples, people were potentially being put at high risks of cross contamination with food preparation as two staff balanced dealing with the day to day running of the home with food preparation. This staffing issue is being dealt with in the safe area of this report.

People who preferred to have their meals in their own bedrooms, were able to do so. One person said, "I sometimes like to have a meal in my bedroom. I can take my time and prefer that sometimes."

From people's care records we saw that people who had particular nutritional needs, had those needs met, for example, those who were diabetic. Being a diabetic means you suffer from a condition where the amount of glucose in your blood is too high because the body cannot use it properly. Therefore it is extremely important that this is monitored and the correct diet eaten. We also noted that where people were at risk of malnutrition or who had particular concerns with food; they had been referred to more specialist teams or healthcare professionals to assist with this. We noted one person's records stated that they preferred to use a bowl and spoon due to living with arthritis. We saw that they were able to have their needs met during lunch and at other times.

We observed refreshments were available throughout the day to people, including those who preferred to stay in their own bedrooms. One person told us, "We get tea brought to us in a morning after breakfast and in the afternoon after dinner. ....also at night around supper time." We asked a group of six people if they could ask for a cup of tea or other drink when they needed one outside of the usual times. One person replied, "I have never asked for one, but I think they would bring one to you if you needed another."

People told us that staff supported them to access healthcare services. Records showed details of appointments with and visits by health and social care professionals and we saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed, for example GP's, district nurse teams, social workers and chiropractors. One person received a visit from a GP on the day of the inspection which we were told was part of an on-going treatment and care plan.

The premises was adapted for people in wheelchairs and those with limited mobility. For example, doors were wide enough and lifts were operational with hoists available for those people who required that level of support. The garden area was well established and accessible, although we have asked the provider to improve a stepped area.



## Our findings

People and relatives were complimentary about the caring qualities of staff and told us that staff were caring, patient and treated them well. We noted many compliments on display in the reception area with expressions of thanks from people who had either stayed at the service or from relatives whose loved ones had stayed and passed away.

One person said, "They are always very kind." Other comments included, "They look after me well" and "They are lovely." One relative told us, "I knew more or less straight away that this was the right place. I feel much less stressed now. We spoke with a district nurse who said, "They are always very welcoming...It is a lovely home one of the better ones I would say..... would recommend any family member." The GP told us, "From what I have seen the staff are very caring. I would not hesitate to recommend the service."

A care worker brought one person a cup of tea. We heard the care worker showing warmth and kindness as they talked to the person about how they were feeling today and how their family were coming to visit them soon. They talked for a few minutes about general day to day issues, like the weather and what was for lunch and then the care worker excused themselves to go and speak to another person about what they wanted help with. One person told us, "I wish they [staff] had more time to come and chat with me, but I know they do their best and try very hard to see to everyone." Another person commented on how nice the care staff were but said that they wished they had more time to spend with them.

One relative told us, "My relative is in here and it's lovely, she came in originally for respite. We think it is very good, there are a few of us and we come in often. We have got used to the staff now and we talk to them and they talk to us.

Relatives told us they were made to feel welcome at service when they were visiting their family members. One relative said, "This home is excellent, the staff make you so welcome. I can visit any time and I know [Relative's name] is well looked after." We saw from compliments records that relatives had provided feedback on how staff had made them feel welcome and comments on the caring attitude of staff with appreciation of what work they had done.

We observed the care and support people received during our visit. We saw that staff treated people well. For example, we saw staff explaining what was happening and giving people choices throughout the day. When care tasks were carried out, such as moving and handling, staff offered explanations and reassurance while the task was being completed.

People who needed support with meal times received that support in a respectful way. People were not hurried and people's dignity was maintained at all times. Staff were seen knocking on people's doors before they entered and being mindful of protecting people's privacy. This all meant that staff were aware of maintaining people's rights to privacy and the need to promote people's dignity.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs, but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

In the reception area of the service there was a variety of information on a number of topics, including for example, information on services in the area. This meant the provider ensured that information was available to support people in a variety of themes that may have been helpful to them and support them in the local community.

Staff were overheard prompting and encouraging people throughout the inspection. For example, we overheard one person being encouraged to participate in their personal care needs with staff supporting them to remain as independent as possible. Many people were independently mobile and were able to move around the service freely.

Although information about advocacy services was not available within the reception area of the service, staff were aware of how to access this type of provision if any person required it. At the time of the inspection we were told that no one living at the service was using an advocate. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. Staff told us, "If anyone needed further help, we would make sure they got it."

### Our findings

People told us they there were some activities which took place in the service and that they had their own interests to be involved with. Staff confirmed that the provider booked entertainers to attend the service for sing-along-sessions and also a person who completed armchair exercises with people every month. One person told us they enjoyed reading and watching the television. Another person told us, "I go out with my family for meals and shopping." One person told us they went to local community centres with friends to participate in activities there. Staff told us, "We do nail painting and play puzzles and other games with people." When we asked how they fitted these activities in with the other work they had to do, they told us, "It can be hard but we usually have time to do something." During the inspection, we saw little evidence of stimulating activities taking place in communal areas as staff were busy with other daily tasks. We saw several people sat for most of the day in the lounge and did not engage in any meaningful activity. We observed that there was no dedicated activities staff member and there was not enough staff to complete meaningful stimulation, particularly with those people who had the early stages of dementia. This meant that people who were less capable of seeking their own activities were less likely to participate in any stimulating activity during the day because of low staff numbers. It also meant there was not always access to meaningful activity to support people's social and psychological wellbeing.

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

People told us they were happy with the way staff met their needs. One person said, "Staff know what I like and how I like it. If I want to stay in bed I can, but if I want to get up sooner I can do that too." Relatives told us staff responded to people's needs well, one said, "I have no concerns about how the staff do their job and how they react to [person's name]. ....we have always been included and as we are here all the time, we would know if something was not right."

Relatives told us that they were fully involved with ensuring that their relatives care needs were met and felt they were updated regularly by the staff team. On person said, "Cannot fault the girls.....they do a good job and seem to deal well when something has happened."

People's needs were assessed before they moved into the service to ensure their needs could be met. This information was collated from the people interested in moving in, their relatives and healthcare professionals if they were involved. People were encouraged to visit the service before a final decision on moving in was made. This included staying for lunch or tea or having an overnight stay. It was only when

people were happy to move in that the final decision was made and relevant paperwork put in place.

Records were in place and reviewed monthly, which informed staff of the needs of people who lived at the service and how they preferred to live day to day. For example it was documented in one person's records that they liked all food, but would let staff know otherwise. Another person, for example, had documented that they required support with their personal needs and how they preferred to be helped with using the toilet. We saw care plans detailing, for example, personal care, mobility and sleep needs. During our discussions with the deputy, they told us that they were going to update the care records to improve the layout and format of the recording to ensure that only people's needs were followed with a care plan, as we found that some people had a care plan in place but no need had been identified.

The nurse we spoke with thought that care was person centred. They told us over the time they had been visiting they had seen some good examples of this. Staff knew people well and we observed this in the way they were able to answer questions about people without documentation to hand. Staff were able to tell us how different people liked to have particular elements of their care delivered. For example, they knew that one person preferred staff not to help them with morning hygiene routines, but liked to be overseen if they used bathing equipment and were able to explain the routine they went through. This showed that the provider worked to ensure people were treated with person centred care which was tailored to the individual.

The provider had produced a handover record to go with people if they were transferred to hospital or another service. We noted that the record had a list of current medicines that people were receiving. However, we noted that one person's had recently gone out of date due to a change of prescription. After discussion with the deputy manager, they told us that copies of the medicines administration record would be attached to the record if people were transferred to another service as this would ensure that medicines information was always up to date.

On the day of the inspection, a hairdresser had called to complete hair care for people who wanted to participate. One person told us, "They do a lovely job...I look forward to having my hair done." We were later told that the hairdresser had attended the service for many years and knew the people well.

People were offered choice in what (or if) they wanted to eat or drink and when they wanted to get up in the morning. They were also offered the choice of taking their medicines or not. We noted on the day of the inspection, that one person was asked if they wanted any of their 'as required' medicines. They refused and the staff member respected their choice and recorded the refusal in the records. We also noted that people were able to have their own telephones installed in the bedrooms if they so wished. One person told us, "I use mine to ring my family."

People and their relatives told us they were listened to by the staff and the provider. One person told us, "There were some teething problems when I first moved in, but staff soon sorted those out." A relative told us, "The manager listened to what we wanted and no sooner said than done." Another relative told us, "They [staff] have done nothing but good since [person] came to live here. [Person's name] is not the easiest person in the world and the staff have listened and been great with them." Staff at the service told us that a 'residents' meeting was going to be held in the forthcoming weeks as they had not had one for a while. We noted that the last meeting had been in July 2015. Surveys however, were completed yearly to ask people anonymously what they thought of the service and gain feedback. We found that the surveys returned contained positive feedback on all occasions.

The provider had a complaints policy and information was displayed within the service on how people

could complain if they wished and people and their relatives knew how to use it. There had been no complaints made since the last inspection. One person told us, "If I had to complain, I would have no hesitation as the girls would put things right.... However, I have had no need to complain." A relative told us, "I am sure that [deputy manager's name] or [registered managers name] would be quick to respond if anyone complained as they try their very best here and would be upset to think someone had to resort to complain.... I am sure they would look into the matter straight away."



## Our findings

We found that quality assurance needed to be improved although a number of checks and audits were already in place. There was no recorded evidence of the providers oversight and management of the service.

The deputy manager told us they completed competency checks on staff administering medicines, however, they were unable to show us any documented evidence that this had occurred. We found no evidence that the registered manager/owner had done anything to rectify this or asked to have documents put in place.

The deputy manager kept a training matrix of all training which staff had completed and were aware of the gaps in staff training when we discussed this with them. We asked if the registered manager was aware and they said they were. We saw no evidence to suggest that the registered manager/owner had sourced future training for staff to participate in.

We saw copies of the legionella risk assessment with actions outstanding and the infection control audit which had been completed by the local authority lead also had outstanding actions. This meant that the provider had not taken swift action to improve the quality of the service provided and mitigate against risks that had been identified.

The Commission had previously, on a number of occasions discussed the need to monitor the level of people's dependency at the service, however we were not able to find any evidence of this being completed. The registered manager/owner had not addressed other issues, for example the concerns with the legionella risks and training concerns and were only spurred into action because of the inspection.

We found that no hand hygiene audit had taken place since 2014. These are checks to ensure that hand washing procedures were followed and both staff and visitors are following good practice guidelines.

In the cellar area of the property we found one room used to store people's archived personal information and care records. These were kept in and on an open filing cabinet within an unlocked room. The room also had unsealed windows which led to the outside of the building. This meant that personal sensitive information had not been stored securely and had the potential to be misused.

We considered that the provider had various checks which needed to be consolidated to ensure that no

areas went unmonitored and used best practice guidelines to achieve this, including a full and comprehensive environmental and health and safety audit.

There was little evidence throughout the inspection of oversight by the registered manager/owner and it appeared that the deputy manager was the person in day to day control of the management of the service. The registered manager/owner had no system in place to oversee the practice and quality of the service other than what the deputy manager had put in place.

Meetings for people and their relatives to offer feedback to the service had not been regularly held and in the Provider Information Return (PIR) that the provider had returned to the Commission in January, they told us that meetings were going to be held more regularly. We saw that the last one had been held in July 2015.

These were all a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to good governance.

Falls that people had were analysed to see if any issues were common and stop these occurring in the future. People's pressure areas were monitored to check for healing and a district nurse commented that staff at the service worked well with people who had skin damage and gave us an example of where staff had improved one person's skin condition because of the monitoring. Checks on daily medicines had taken place to ensure that all medicines were accounted for and these were done without fail every day.

At the time of our inspection there was a registered manager/owner in place who registered with the Commission in 2010. The registered manager had owned the service for over 20 years and currently worked a few days per week at the service in a caring role. They were not present throughout the inspection, but were called by the deputy manager to be informed that we were undertaking an inspection and site visit.

The deputy manager was not registered with the Commission. We asked the deputy if there had ever been any discussion in connection to them becoming the registered manager and they told us they had considered this.

People knew the registered manager/owner and those that were able, remembered her name. She appeared to be well liked by the people living at the service, although it appeared that the deputy manager was more thought of as the 'overall manager'. The deputy manager and registered manager/owner spent the majority of their time at the service completing caring or other tasks related to the support of the people who lived there, with no additional time built in to enable them to fully monitor the quality of the service provision and complete management tasks.

Staff meetings had rarely taken place, although staff told us that they felt supported and were able to raise any issues with the management of the service as and when they arose. Staff told us that they liked working at the service. They told us that the registered manager was often working at the service and had opportunities to speak with her then. One staff member said, "[Registered manager/owners name] is working here tomorrow, she covers a couple of days a week normally." The deputy manager confirmed that the staff team supported each other very well. One staff member told us, "We are a good team and look after each other."

The provider had completed a provider information return (PIR) in January, which stated that meetings for people who lived at the service were going to be held five times per year. We found that there had been none since 2015. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked some of the other

information provided on the PIR and found that many of the actions described for future development had not taken place. For example, training was recorded as going to be booked by February 2016 and more activities being made available. We found these actions had not occurred and the likely contributor was there was not enough management time dedicated to the service.

The deputy manager told us the ethos of the service and the whole staff team, was to remain "homely" and continue to have staff that "really care about people living there". They said that people's care needs had increased over recent years and they worked together as a team to maintain people within the service for as long as possible.

It was clear that the deputy manager was passionate about learning more and developing the service for the registered manager/owner. All of the healthcare professionals that we spoke with were complimentary about the management at the service and the 'person centred' culture they promoted and also the positive working relationship they had with each other. We saw this when the GP and the district nurse visited.

We saw that electronic copies of people's records were stored on a password protected computer. This meant that people's personal and confidential information was protected when stored electronically.



## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>People's care and treatment was not always appropriate or meet their psychological or social needs.</p> <p>Regulation 9 (1)(a)(b)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>There was not sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people at the service.</p> <p>Regulation 18 (1)(2)(a)(b)</p>

# Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People were not protected from unsafe care and treatment because effective measures to ensure the premises were safe had not been put in place, there was not enough staff to effectively meet people's needs, risks had not always been assessed, medicines were not always stored safely and appropriate measures were not in place for preventing, controlling and detecting infections.</p> <p>Regulation 12 (1)(2)(a)(b)(c)(g)(h)</p>

**The enforcement action we took:**

We have issued a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems were not in place to ensure compliance with regulations because audits had failed to assess, identify and mitigate risks. Records were not always stored securely.</p> <p>Regulation 17(1)(2)(a)(b)(c).</p>

**The enforcement action we took:**

We have issued a Warning Notice against the provider.