Mr & Mrs G A Shone

Gerald House

Inspection report

4 Gerald Road
Prenton
Wirral
CH43 2JX
Tel: 0151 652 1606

Date of inspection visit: 20 and 25 January 2016
Date of publication: 28/04/2016

Ratings

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

Overall summary

Gerald House is a detached property situated in Prenton. The home provides accommodation with personal care for older adults and people with mental health needs. There are 16 individual bedrooms and one shared bedroom situated across three floors. There is a passenger lift to enable people with mobility issues to access the upper floors of the building. Most of the bedrooms have en-suite toilet facilities with specialised bathing facilities available in communal bathrooms. There is a garden area to the front and rear of the property with a small car park.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.' The registered manager was not present during our visit and did not participate in the inspection. The assistant manager assisted us with our inspection.

Summary of findings

During our inspection, we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014 in respect of Regulation 12, 17, 18 and 19 of the Health and Social Care Act 2014 Regulations.

These breaches related to the safety of the premises and its equipment, infection control, medication management, staff recruitment, training and supervision and the management of the service. You can see what action we told the provider to take at the back of the full version of the report.

During our visit, we found that some areas of the home were in need of repair and improvement to ensure they were suitable for use. We found that systems at the home such as gas, fire, the nurse call bell system and the moving and handling equipment in use at the home were not appropriately maintained and inspected to ensure they were safe for use. This placed people at risk of physical harm.

We observed that staffing levels at the home were satisfactory and people who lived at the home confirmed this. We looked at five staff files. We found staff were not always recruited appropriately to ensure they were safe to work with, and had the skills and experience to care for vulnerable people. Once employed, some staff had not received adequate training or supervision to do their job role effectively. This placed people at risk of receiving inappropriate and unsafe care.

Arrangements for the administration of boxed or 'as and when required' medication were unsafe. Insufficient administration instructions were handwritten on people's medication administration charts which meant that staff did not have adequate guidance on the amount of medication to administer, its frequency or its purpose. This meant there was a risk that this medication would not be given in accordance with prescribed instructions. Procedures to check that medication was stored at the right temperatures were also not in place.

The home was clean and free from odours on the day of our visit. Infection control standards at the home however required improvement. Hand hygiene facilities and the procedures for the handling of people's laundry items were inadequate and did not adhere to the Department of Health's 2008 Code of Practice on the prevention and control of infections. There were also no system in place for the identification and control of legionella bacteria in the home's water system. These inadequacies placed people at increased risk of contracting an infection.

We looked at three care files and found that the majority of people's risks were assessed and managed. Some healthcare risks such as those associated with specific medical conditions or special dietary requirements had not been properly considered in the planning and delivery of care. This aspect of risk management required improvement to protect people from harm.

Care plans were person centred and gave staff an insight into the person they were caring for. People who lived at the home with mental health needs were involved with appropriate mental health services. Where people had mental health issues however, care plans lacked adequate information on how these issues impacted on their day to day lives and decision making. Staff had also not received any specific mental health training. This meant staff at the home may not understand how to respond to and promote a person's mental and emotional well-being.

We saw some evidence of the beginnings of good practice in relation to the Mental Capacity Act 2005 legislation. The provider had applied for a deprivation of liberty safeguard in respect of one person at the home to keep them safe. A mental capacity assessment had been undertaken. There was evidence of best interest discussions with the person and related professionals involved in their care and staff at the home had a clear strategy for minimising the restrictions placed on the person which had been agreed and implemented. We found that the requirements of the Mental Capacity Act required implementation for other people at the home with similar needs.

We looked at the opportunities for social engagement at the home and found that people's social needs were not properly promoted to ensure a good quality of life. People we spoke with told us activities, events and outings at the service were infrequent and there was no evidence that any organised activity programme was in place. This meant there was no evidence that the provider ensured people had access to activities and interactions that promoted their emotional well-being.

Summary of findings

People's nutritional needs and risks had been assessed and people received sufficient quantities of food and drink. People we spoke with where happy with the quality of food provided. People told us they were happy with the care they received and said they were well looked after. They

told us that staff were kind and treated them with respect. We found the atmosphere at the home to be calm and homely. From our observations it was clear staff knew people well. Staff we spoke with had an understanding of people's needs and preferences and spoke warmly about the people they care for. People's views on the quality of the service had been sought in October 2015 with positive results.

Overall we found the management of the home inadequate. There were no effective systems in place to assess and manage the risks to people's health, safety and welfare. There were no effective systems in place to ensure the quality of the service was of an appropriate standard. Policies and procedures in the majority were out of date and the management of the service was found to be ad hoc and reactive. The service was not well led and did not guarantee people received safe, effective, caring and responsive support.

At the end of our visit, we discussed the concerns we had about the service with the assistant manager. They were unable to provide a satisfactory explanation as to why the issues we identified during our inspection had not been picked up and addressed.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 who lived at the home told us they felt safe at the home.

Staff knowledge of safeguarding required improvement to ensure they were able to recognise potential signs of abuse.

The majority of people's risks in the delivery of care were assessed but risks in relation to specific medical conditions had not been properly considered.

Staffing levels were sufficient to meet people's needs but staff were not always recruited safely.

The arrangements in place for the administration of 'as and when' required medication was unsafe.

The premises and its equipment were poorly maintained and there was no evidence they were safe and suitable for use.

Is the service effective?

Requires improvement 

The service was not always effective

Staff had not received appropriate induction, training and supervision to do their job role effectively.

There was some evidence of good practice in respect of the Mental Capacity Act but this required further development.

People received enough to eat and drink but people's nutritional information was limited and did not fully identify potential risks.

Is the service caring?

Good 

The service was caring.

People we spoke with told us the staff were kind and treated them with respect. Our observations confirmed this.

Staff had an understanding of 'the person' they cared for and were able to describe their needs and preferences.

People's independence was promoted and the atmosphere at the home was warm, welcoming and homely.

People's end of life care planning was limited and there was little evidence end of life discussions had taken place.

There were limited opportunities for people to be involved in the running of the service on regular basis. Information about the service was out of date.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care plans contained person centred information but information about people's mental health needs was limited.

Staff supported people in a person centred way and it was clear that people were relaxed and comfortable in the company of staff.

There was no suitable activity programme in place to promote the emotional and social well-being of people who lived at the home.

Information on how to complain was available but it was out of date and insufficient.

Is the service well-led?

Inadequate

The service was not well led.

There were no effective quality assurance systems in place to monitor the quality or safety of the service. This placed people at risk of potential harm.

The management of the service was poor and found to be ad hoc and reactive.

People's opinions of the quality of the service had been sought.

Gerald House

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 25 January 2016. The first day of the inspection was unannounced. The inspection was carried out by an adult social care (ASC) Inspector. Prior to our visit we looked at any information we had received about the home.

During the inspection we spoke with four people who lived at the home, a visitor, three care staff, the cook and the assistant manager. We also spoke with a supplier of services to the home.

We looked at the communal areas that people shared in the home and a sample of individual bedrooms. We reviewed a range of documentation including three care records, medication records, five staff files, policies and procedures, health and safety audits and records relating to the quality checks undertaken by the manager.

Inadequate

Is the service safe?

Our findings

All of the people we spoke with said that they felt safe at the home. One person told us staff were "Quite nice", another said that the staff were "Very, very, very good". A visitor we spoke with told us "Staff are lovely". They said they visited the home regularly and felt confident that the person they visited felt safe and happy at the home.

We spoke with one staff member about safeguarding people from the risk of abuse. We found that this staff member knew who to report any safeguarding concerns to, but they were unable to tell us about the types of abuse that could potentially occur. This meant there was a risk that potential signs of abuse could go unrecognised if and when they occurred. We asked the assistant manager if staff at the home had received training in safeguarding vulnerable adults. The assistant manager told us that they had but, was unable to show us any up to date evidence to confirm this. We saw that the provider had a policy and procedure in place for identifying and reporting safeguarding incidents but this policy was out of date and failed to provide details for the local authority safeguarding team and the Care Quality Commission to whom allegations of abuse should be reported.

During our visit, we did a tour of the building. We found that some areas were in need of repair and improvement. For example, we saw that the toilet roll holder in the ground floor bathroom was broken, the emergency call bell lead was not long enough for people to reach and books were piled behind a bathroom door. In one of the downstairs toilets, the hot water tap was not fixed and twisted around when used and the toilet flush did not work properly. One of the hallway carpets was stuck down with masking tape and the curtains in one person's bedroom were falling off the curtain rail. This showed that parts of the home were inadequately maintained.

We found that the provider's call bell system did not facilitate a prompt staff response to people's calls for help. The call bell panel which pinpointed the location from which the call was made was situated in a corridor on the ground floor. There were no other call bell panels in place for staff to refer to. Staff had to go to ground floor to check the call bell panel for the caller's location before they could respond. This meant that if staff were not on the ground floor when a call bell was pressed there was a risk that people could experience a delay in receiving the support they needed. Call bell points were also not accessible in communal areas to enable people to call for help as and when required. This meant there was a risk that people's needs could go unmet.

We found that the home's call bell system had not been properly inspected or maintained since 2013 and there was no evidence that the provider checked the system regularly to ensure it was in full working order.

We asked the assistant manager for evidence that the home's gas, electrical and fire alarm systems were regularly inspected by external contractors and conformed to recognised safety standards. Evidence that the electrical system had been tested as safe was provided. Records in relation to the gas installation showed that the home's gas boilers were certified as unsafe by British Gas in April 2015. When asked, the assistant manager did not know what action had been taken by the provider to address the safety concerns identified by British Gas. The assistant manager rang British Gas during our visit. We spoke with the British Gas Team. They told us that the system in place was not 'immediately dangerous' but advised there was no record of any remedial work being undertaken or evidence that the gas system was safe to use.

We saw that the home's fire alarm system was due to be re-tested in December 2015. There was no evidence that this had been undertaken which meant there was no evidence that system was free from defect and suitable for purpose.

After our visit, The Commission received an email from the assistant manager to advise that arrangements had been made for necessary safety checks and remedial work to be completed.

There was personal emergency evacuation information in place for people who lived at the home but this information was insufficient. People's evacuation information failed to specify the person's bedroom, provide any information on mobility or the equipment that people may require to safely evacuate the building. This meant that emergency personnel may not have all of the information they need to enable people to be evacuated efficiently.

Specialised moving and handling equipment such as a mobile hoist or bath hoist enable staff to assist people with limited mobility to transfer position safely. By law, providers are required to ensure that all moving and handling

equipment is fit for purpose and appropriate for the task. Providers have a legal duty to ensure that all lifting equipment is subject to statutory periodic thorough examination every six months by a competent person. These examinations are called LOLER (Lifting Operations and Lifting Equipment Regulations 1998) tests.

We asked the assistant manager for evidence that these tests had been undertaken in respect of the moving and handling equipment in use at the home. The assistant manager was unable to find any up to date test certificates. This meant there was no evidence the equipment was safe to use. Shortly after our inspection, we received confirmation from the assistant manager that arrangements were in place to ensure the LOLER tests were undertaken.

These incidences were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to ensure the premises and its equipment was safe, suitable for purpose and met statutory requirements.

We looked at five staff files. We found staff were not always recruited safely. Each staff file contained evidence that proof of identify checks had been completed prior to employment and references sought. Some staff members' files however lacked an appropriate application form or evidence that a contract of employment was in place. For example, one staff member's application was barely readable as the handwriting was so poor. The application form had not been signed and dated, the post applied for did not correspond to the position the person was employed in and there was no contract of employment in place.

Some staff criminal conviction checks had not been undertaken prior to employment. For example, one staff member's file contained a criminal conviction check dated 2009 but there was no evidence that a new criminal conviction check had been undertaken by the provider prior to their employment at the home in 2012. Some criminal conviction information in staff files had not been checked since the person was first employed. For example, one person's criminal conviction information was ten years old which meant there was a risk this information was out of date. Where staff members had declared criminal convictions prior to their employment, an assessment of any potential risks had not been considered by the provider as part of the recruitment process.

These examples demonstrate a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider had not ensured that persons employed were of good character and had the skills and experience to provide safe and appropriate care.

People who lived at the home said that the number of staff on duty was sufficient to meet their needs. Two care staff were on duty during the day in addition to the assistant manager and domestic staff. After 10pm, one staff member was on duty and another staff member did a 'sleeping' shift. This meant that they were 'on hand' to support the other member of staff as and when required. The staff rotas we looked at confirmed this.

People's medication was stored securely in a locked medication room. On the day of our visit, the medication room was very warm and lacked any adequate ventilation when the door was closed. A staff member told us that during the summer months, the medication room got very warm. We asked the assistant manager if any trolley or room temperatures were undertaken to ensure medicines were stored at the appropriate temperature. The assistant manager told us no temperature checks were undertaken. This meant there was a risk that medication may have been stored at inappropriate temperatures and may have been unsafe to use.

We did a random check of the quantity of medication in the medication trolley. We found that the balance of medication matched what had been administered. We saw that most items were dispensed in blister packs. Blister packs are individual containers of the person's medication. Medicines which were not blister packed were mainly 'as and when required' medication such as antibiotics or painkillers.

We found that details of people's 'as and when required ' medication had been handwritten on their medication administration records (MARS) without being appropriately signed for or double checked by a second member of staff. Some handwritten entries provided limited guidance to advise staff under what circumstances the medication should be given, limited guidance on the dosage and frequency of the medication to be given and limited guidance on how it should be administered. This meant

Inadequate

Is the service safe?

there was a risk that staff may not administer this medication in a safe and appropriate way or for the purposes it was prescribed for. This placed people at risk of harm.

For example, one person's painkilling medication had been handwritten on their MAR without any indication of the dose to be given or the times and frequency of its administration. It was also unclear under what circumstances the medication should be given to manage the person's pain level appropriately.

These issues demonstrated that the way in which medications were ordered and accounted for at the home required improvement. This was a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was clean and free from odours. Communal toilets and bathrooms however did not have adequate hand hygiene facilities to prevent the spread of infection for example, hand soap and disposable hand towels for people to use. Staff did not employ good infection control procedures when handling people's laundry items. The provider had no systems in place to monitor and manage the risk of Legionella. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety Act 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have systems in place to assess, monitor and prevent the spread of infection.

We looked at the care plans belonging to three people who lived at the home. We saw that risks in relation to malnutrition, falls, moving and handling, self-administration of medication were assessed. Risk management guidance in relation to these risks was brief but easy to understand. Some specific healthcare risks required further assessment. For example one person had a medical condition that placed them at risk of seizures. No risk assessment in relation to this had been completed or management advice put in place to guide staff on how to respond to a seizure if one occurred. This meant there was a risk that staff may not know what to do.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to adequately assess and mitigate all of the risks to people's health, safety and welfare.

Requires improvement

Is the service effective?

Our findings

All of the people we spoke with told us they were well looked after by staff at the home. People's comments included; "Staff are genuine and have compassion. They couldn't do any more for me" and "They (staff) are very good".

We looked at the training records in the personnel files of five staff members to check that staff were appropriately trained to care for people effectively. We found the majority of staff training required refreshment to ensure it was up to date. Some staff members had also not received appropriate training with relation to safeguarding, infection control, moving and handling and mental capacity. For example, there was no evidence that two members of staff employed at the home within the last 12 months had received any training since their initial induction into the service. This meant there was no evidence that they had the skills and knowledge to care for people safely.

We saw that some people who lived at the home had specific mental health conditions. We checked in the five staff files we looked at, to see if staff had access to training in mental health and challenging behaviours in order to support people with their mental health needs. We found that only one member of staff had any adequate mental health training and this training had been undertaken two years prior. Some staff had completed training in dementia care but had received no other training in relation to the mental health conditions some of the people at the home lived with. No training in challenging behaviour had been provided despite the provider's policy stating all staff received this training. This meant there was a risk that staff did not have the skills and knowledge to provide safe and appropriate care.

When we asked the assistant manager how the provider monitored staff training to ensure that staff had the required skills and knowledge to care for people safely, we were told there was no monitoring system in place. This meant that there was no suitable system in place to ensure that staff were adequately trained to carry out their role effectively and to an appropriate standard.

We talked to one staff member about the support they received from manager and assistant manager. They told us they felt supported in their role. We checked staff files for evidence that staff had received supervision and had an appraisal of their skills and competencies in their job role. We found that the majority of staff had received an appraisal but the supervision of staff was inconsistent across the staff team. Some staff files contained no evidence that any supervision meetings had taken place with their line manager since the staff member was appointed.

For example, one senior member of staff had no supervision records in their file to indicate they had received appropriate support and managerial guidance. Two staff members employed within the last 12 months had no evidence that they had been supervised since their appointment. One staff member's last supervision record was dated 2009, and another's was dated 2011. This demonstrated an ad hoc, inconsistent approach to the supervision and support of staff.

We asked the assistant manager how the supervision of staff was organised and monitored to ensure staff received sufficient support. The assistant manager told us that the supervision of staff was undertaken on an ad hoc basis when a training need was identified. This meant there was no management system in place to ensure staff were supervised and supported in their job role.

The assistant manager told us that the manager kept a diary of any ad hoc supervisory conversations that they had taken place with staff members, but, on the day of our inspection, this diary was not available to view.

These examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure staff received appropriate training, supervision and appraisal in their job role.

Some people who lived at the home had specific mental health conditions. We saw evidence that advice from mental health services and social services had been sought and referrals made as and when appropriate for people who lived with mental health issues. This ensured people had access to the professional support they needed.

Information in people's care files about their mental health conditions was limited. For example, some care plans did not fully explain what the mental health condition was or its impact of the person's day to day life. Where people had dementia type conditions or short term memory loss, care plans lacked sufficient information about how these conditions impacted on the person's ability to consent to

Is the service effective?

any decisions made about their care. This meant that some care plans provided little guidance to staff on how to support people's mental health. This was further complicated by the fact that staff had not received any specific training in mental health. This meant there was a risk that staff would not understand how to respond to people's mental health needs in order to support their mental and emotional well- being.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met.

The assistant manager told us that a Deprivation of Liberty Safeguard application had been made for one person who lived at the home. This application had been approved by the Local Authority. We looked at the DoLS information and saw that the safeguards put into place prevented the person from leaving the home of their own accord. We saw that a mental capacity assessment had been completed in relation to this decision. There was evidence that the person had been involved in discussions about this deprivation of liberty and had consented to the conditions. We saw that the home had ensured that this deprivation was as least restrictive as possible to enable the person to maintain as much of their independence as possible. The way in which this person's deprivation of liberty safeguard was put into place demonstrated the beginnings of good practice in the Mental Capacity Act 2005.

There were other people at the home whose capacity may have been in question but whose capacity had not been assessed. These people may have benefitted from a capacity assessment being undertaken as and when specific decisions needed to be taken. We spoke with the assistant manager about this. For example, one person's file showed that they had been assessed as lacking capacity in 2013 but there was no assessment paperwork in their file or information relating to the decision the assessment referred to. There was no further evidence that any other capacity assessments had been completed in respect of this person's care, no information relating to the type of decisions this person was able to make or the support they required in decision making. This demonstrated that the implementation of the MCA was inconsistent at the home and required development to ensure legal consent was always obtained.

People we spoke with told us they got enough to eat and drink. They said that the food was good but they didn't really get a choice. They did however confirm that if they didn't like what was on offer, the chef would provide them with an alternative meal.

We looked at the menu planning arrangements at the home and saw that menus were planned on a four week rolling basis. We noted that the majority of meal from one week to another contained very similar dishes which did not provide much variety. We observed the serving of lunch. We saw that people had the choice of eating their meal in the dining room, the lounge or in their own bedrooms. Meals were served promptly and pleasantly by staff and portion sizes were adequate. We saw that throughout the day people had access to sufficient quantities of food and drink.

We looked at the home's food stores and saw that they were well stocked. Information in relation to people's special dietary requirements was available in the kitchen area for catering and care staff to refer to and suitable management systems were in place to maintain good food hygiene procedures. We saw that the home had recently been inspected by Environmental Health and were given a rating of 5 (very good) in March 2015 for its standard of food hygiene.

We saw that people whose care files we looked at were weighed regularly and have maintained a steady weight. Information in people's care files about their nutritional needs and risks however was very limited. For example one person's care plan identified the person had swallowing difficulties and some simple management actions were documented to advise staff how to manage this risk. The type of diet the person required and any foodstuffs the person should avoid to prevent a choking incident had not

Requires improvement

Is the service effective?

been identified. We found therefore that people's nutritional needs required further assessment and care planning to ensure that people's needs, risks and preferences were catered for.

Records showed that people had prompt access to medical and other support services as and when required. We saw that people's health needs were followed up promptly and acted upon where required. People we spoke with confirmed this.

Some people who lived at the home lived with dementia. We found that improvements to the décor and style of the home were needed to ensure the home was dementia friendly. For example, personalising people's bedrooms doors, the use of different colour schemes and appropriate signage to assist people with dementia to mobilise around the home independently.

Good

Is the service caring?

Our findings

We asked people if staff treated them well. People said that they did. People we spoke with spoke positively about the staff at the home. People's comments included "Oh yes they look after me well"; "They are very good" and "Oh yes I am spoilt. They give me personally all that I need. Staff make a point of coming in to see me".

We observed staff throughout the day supporting people who lived at the home. The atmosphere was warm and welcoming. People looked well dressed and cared for. Interactions between staff and the people they cared for were positive. All the staff we observed were respectful of people's dignity and supported them at their own pace. It was clear from our observations that staff had good relationships with the people they cared for.

We spoke with one member of staff about one of the people whose care files we had looked at. This person had a good knowledge of the person's needs and risks and 'the person' themselves. It was obvious from our discussion that the staff member knew the person well and they spoke about them warmly.

We found the assistant manager to be calm and compassionate in all of their interactions with people and staff. When we asked the assistant manager about the people they cared for, they gave clear information about people's needs and care and were able to tell us about the person's preferred daily routines. This indicated that the assistant manager and staff at the home were fully involved in people's care and day to day lives.

The day before our visit. a new person had moved into the home to live. We saw that staff made a specific effort to visit this person and introduce themselves throughout the day. They made frequent visits to ensure the person was settled and comfortable and we heard them chatting to the person about what they liked and didn't like, for example, do they drink coffee or tea etc., each time they visited. This showed that staff were proactive in ensuring positive relations were developed with people from the start of their stay and that they were made to feel welcome. This enabled the person to experience a positive transition to the home.

We saw that people's care was planned to promote and maintain the person's independence. Care plans outlined what tasks people could do independently and what they required help with. People were able to mobilise freely about the home and staff supported them with their needs in a patient and unhurried way.

The home had recently been accredited for end of life care planning but at the time of our visit, care files contained little evidence that end of life discussions had taken place with people . This aspect of care planning required development in accordance with their recent accreditation.

No regular resident/relative meetings took place to enable people to be involved in discussions about the running of the home. A service user guide was available and provided information to people about the home and the care provided. Some of this information was out of date. For example information about how people could make a complaint referred to out of date legislation and contact details.

Requires improvement

Is the service responsive?

Our findings

People we spoke with told us that they got to choose how they lived their life at the home and that they were happy with the care provided. One person said “They treat you as a person, not as a number. I’m quite happy here”. Another person told us that they could “Pretty much” please themselves how they lived their life.

We asked people about the activities on offer at the home to occupy and interest them. One person told us that the home had provided some Christmas entertainment and on the second day of our inspection, we observed that a ball game was underway in the lounge after lunch between staff and people who lived at the home. People we spoke with however said that generally activities were not a regular feature at the home and events and outings were rare. One person when asked if there was any activities provided said “Not as such”; another said “It’s very, very rare” when we asked if any events and outings were organised by the provider.

We looked to see if there was any information about the activities provided. We could find no information. We asked the assistant manager about this who told us that forthcoming activities were not currently advertised. We asked to see evidence of any previous activities that had taken place. We were told that activities were not currently recorded. This meant there was no evidence that a suitable programme of activities were provided to ensure people who lived at the home lived in a social stimulating environment that maintained their quality of life.

The majority of people who lived at the home had lived there for some time. We observed that staff responded to people’s requests for support on an individual basis and it was evident people were comfortable and relaxed in the company of staff. We saw that staff worked with people to ensure their day to day needs were met in a person centred way. All of the care files we looked at contained person centred information about the person’s needs and lifestyle preferences. This type of information is beneficial in assisting staff to deliver person centred care and showed that people who lived at the home and their families had been involved in discussing and planning their care. Care plans were reviewed on a regular basis to ensure they were up to date.

We looked at the provider’s complaints procedure and saw that it was out of date. It referred to health and social care legislation that was no longer in force and gave incorrect contact details for The Care Quality Commission. Contact details for other organisations people could contact in the event of a complaint were also not provided. For example, no contact details were provided for the Local Authority or the Local Government Ombudsman. This meant people may not know who to direct their complaint to, or which external bodies to escalate their complaint with, should they be dissatisfied with the manager or provider’s response to their complaint in the first instance.

The provider’s complaints policy was stored on a shelf behind the staff desk in the entrance area but was not visibly displayed for people who lived at the home to easily see. We spoke with the assistant manager about this.

Inadequate

Is the service well-led?

Our findings

We asked the assistant manager for evidence of quality monitoring systems in place that ensured the health, safety and welfare of people who lived at the home. Limited evidence of any such systems being in place was provided. This meant the provider had no way of ensuring the care provided to people who lived at the home was safe, effective, caring, responsive and well led.

The provider had no suitable monitoring systems in place to check and quality assure the recruitment and selection of staff. This meant that the provider had no appropriate systems in place to check the qualification, skills and suitability of persons employed prior to employment.

There was no monitoring system in place to check and quality assure the induction, appraisal, supervision and training of staff. This meant the provider had no way of knowing which staff members had received adequate supervision and support. This placed people at risk of poor quality care as the provider did not have an adequate system in place to ensure staff were supported to do their job role effectively.

We saw that the general environment was regularly monitored and regular fire safety checks carried out to protect people from harm. However, the provider had no suitable system in place to check that the systems and equipment in use at the home were regularly inspected and maintained to ensure they met statutory safety requirements. For example, regular testing had not been carried out on the provider's mobile and bathing hoists, the nurse call bell system, the gas installation and the providers' water systems in respect of the risk of Legionella.

We found no evidence that safe water temperatures were checked and monitored by staff to ensure people were protected from the risk of a scald during the delivery of care. We asked a staff member about this and they said that bath temperatures were checked but they were unable to tell us where we could find the thermometers and no bath thermometers were found in any of the bathrooms we looked at. This meant the provider failed to have systems in place to protect people from the risk of physical harm.

We found some risks in relation to people's care were not adequately assessed and managed. Information in relation to people's mental health needs or specific health care needs required improvement and capacity assessments in relation to people's ability to consent to day to day decisions had not been routinely undertaken. We asked if any care plan audits were undertaken to ensure the planning of people's care gave staff adequate information on people's needs. The assistant manager told us that no care plan audits were currently undertaken. This meant there were no adequate systems in place to check that people's assessment and care plan information was accurate and sufficient.

We saw that accident and incidents records were completed as and when accidents or incident occurred. We asked the assistant manager if this information was audited and analysed in any meaningful way to enable the identification of any potential trends in when, where and how accidents or incidents occurred so that preventative action could be taken. We were told no accident and incident audits were undertaken. This meant that staff had no opportunity to learn from the way accidents and incidents occurred in order to prevent them in the future.

We found that infection control procedures at the home were poor. We asked the assistant manager if infection control standards and procedures at the home were audited to ensure they were satisfactory. The assistant manager told us that no infection control audits were currently undertaken. This meant there were no systems in place to ensure good infection control procedures were employed at the home to prevent the spread of infection.

We saw that the provider took responsibility for the management of some people's personal allowances. This enabled people to pay for chiropody services, hairdressing and visits out without having to go to the bank. The manager was responsible for ensuring that people's monies were managed appropriately and properly documented. We saw people's personal monies were stored securely in a safe in the manager's office in individual money wallets. We checked a sample of the balance of people's monies against the receipts maintained by the provider. We found that documentation in relation to people's personal allowance was poorly maintained with no clear audit trail of what spend had occurred and when. This made it impossible to tell if the balance of monies was correct.

We asked the assistant manager if any audits of people's personal allowances were undertaken to ensure they were correctly balanced and properly accounted for. They were unsure. They told us that currently the manager was solely

Inadequate

Is the service well-led?

responsible for people's monies. This meant there was no objective reconciliation or check of people's monies to ensure that the balance of people's monies was correct and properly evidenced. This meant there were no suitable arrangements in place to safeguard people against financial abuse.

These examples demonstrate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because although some audit systems were in place they were insufficient and were not used effectively to assess, monitor and mitigate the risks to people's health, safety and welfare.

We saw evidence that a satisfaction survey was undertaken with people and their relatives in 2015. The response from people and their relatives was mostly positive. This meant people, relatives and staff had had an opportunity to express their views about the quality of the service.

We observed the culture of the home to be open and inclusive. The staff team had a positive attitude. Staff were friendly, welcoming and were observed to have good relations with each other and a compassionate approach to people's care

We spoke with the assistant manager about the concerns we had identified during the inspection. We found the assistant manager to be open and receptive to our feedback. After our visit, we received further confirmation from the assistant manager that action was being taken to ensure improvements to the service were made.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have suitable arrangements in place to ensure that staff received appropriate training, support, supervision and appraisal in their job role.** Regulation 18(2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider had failed to ensure that persons employed were of good character and had the skills and experience to work with vulnerable people who lived at the home.** Regulation 19(1)(a) and (b).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have suitable systems and processes to ensure the premises and its equipment were safe, suitable for use and met statutory requirements. Regulation 12(d) and (e).

The enforcement action we took:
We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have adequate arrangements in place to ensure the ordering of medicines and the way in which medicines were accounted for was safe. Regulation 12(1),(2)(g).

The enforcement action we took:
We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have suitable systems in place to assess, monitor and prevent the spread of infection. Regulation 12(1),(2)(h).

The enforcement action we took:
We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider failed to assess and mitigate risks to people's health, safety and welfare. Regulation 12(1),(2)(a) and (b)

The enforcement action we took:
We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider failed to have sufficient and effective audit systems in place to assess, monitor and manage the quality of the service and any risks to people's health, safety and welfare. Regulation 17(1),(2)(a) and (b).

The enforcement action we took:
We have issued the provider with a Warning Notice. This will be followed up and we will report on any action when it is complete.