Ms Mary Mundy

Towerhouse Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Our inspection of Towerhouse Residential Home took place on 20, 24 and 25 October 2016. At our last comprehensive inspection of the home on 30 November 2015 we found breaches of regulations in relation to safeguarding of people who lived at the home, training and supervision of staff and the provision of regulatory notifications to CQC. We undertook a focused inspection of the home during June 2016 and found that there remained concerns about training and supervision of staff. In addition, at our inspection in June we also found that the home was not meeting the requirements of the law in relation to safe management of medicines. We served two Warning Notices in relation to medicines and the training and supervision of staff.

We carried out this inspection to check the Warning Notices and also to respond to a serious incident at the home which had been reported to us by a local authority. At this inspection we found that the provider had taken action to address some of our concerns about medicines. However, we identified further issues and we found that staff members had not always received training and supervision.

Towerhouse Residential Home is a care home situated in Willesden which is registered to provide care to up to eight older people. At the time of our inspection there were eight people living at the home, the majority of whom were living with dementia.

The manager at the home is the registered provider. Registered providers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection, although people told us that they felt safe, we identified parts of the home which were not safe. The provider had partially addressed concerns about medicines identified in our focused inspection in June 2016. However, we found that there was no internal monitoring of medicines. Medicines were not always given in accordance with the information contained in people's prescriptions and some prescribed creams and laxatives were not recorded as given when we were told by the registered manager and staff that they had been.

The safety of the home environment had not been assessed and managed. Window restrictors had been put in place but these did not meet the Health and Safety Executive's guidance on window restrictors in care homes. Actions had not been put in place to address risk to people living with dementia who were at risk of leaving the home. We also found that risk assessments and management plans were not in place in relation to refurbishment of a bathroom at the home and that people were at risk of trips and falls.

People living at the home told us that they were well cared for. However, we found that two people did not have care plans or risk assessments in place, despite the fact that risks associated with behaviour had been recorded in their care notes. Although care plans and risk assessments were in place for other people, they had not always been updated to reflect changes in their care and support needs.

Staff members supported people in a caring and respectful way. They were able to describe their roles and responsibilities in ensuring that the people whom they supported were safe from harm. However, we found that that there were no formal records of two recent safeguarding concerns and these had not been notified to CQC.

The majority of people at the home were living with dementia and were subject to the requirements of the Mental Capacity Act 2005 (MCA). We found that applications for authorisations under the Deprivation of Liberty Safeguards (DoLS) which are part of the MCA had not been made for three people who met the DoLS criteria of being under constant supervision and unable to leave the home unaccompanied.

Staff members told us that they were well supported by the provider/manager. However, a staff member who had been in post for more than a year had not received core mandatory training and only one staff member had received supervision from the provider/manager since February 2016.

The home provided some activities for people and they were planning to increase the range of these. People's religious, cultural and relationship needs were supported. Faith representatives visited the home and family members were welcomed when they visited.

People had received appropriate support in relation to their health needs. We saw that the home liaised with healthcare professions to address these.

People living at the home and staff members told us that they were happy with the management. However, we found that there had been limited action in relation to quality assurance and management monitoring of the care and support provided by the home. Monitoring and audit processes were incomplete or out of date, and we were not shown how the provider had used these to assess and improve the quality of care.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering what action to take. 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?

Inadequate

The service was not safe. Medicines were not effectively managed.

Two people did not have risk assessments in place and risk assessments for other people had not been updated to reflect current needs.

Risks associated with the environment of the home had not been assessed and managed.

Is the service effective?

Requires Improvement

The service was not always effective. Staff members had not received training or supervision to ensure that they were able to carry out their roles effectively.

Applications for Deprivation of Liberty Safeguards authorisations had not been made for three people.

People's nutritional and dietary needs were met.

Is the service caring?

Requires Improvement

The service was not always caring. People's care documents were not stored securely in order to maintain confidentiality.

Information about people's personal histories and interests was not always known to staff.

Staff members supported people in a respectful and caring manner.

Is the service responsive?

Requires Improvement

The service was not always responsive. Two people did not have care plans and other care plans had not been updated to reflect changes in need.

There were no records that showed that people had been consulted and involved in decisions about the home.

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

Is the service well-led?

Inadequate

The service was not well led. The provider had not provided CQC with regulatory notifications.

Quality assurance processes were inadequate or incomplete.

There were no arrangements in place to ensure continuity of the service should the registered manager be absent for a period of time.

Towerhouse 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 20, 24 and 25 October 2016 and was unannounced. We visited Towerhouse Residential Home on 20 October 2016 to review actions taken by the provider in response to an incident that had been reported to us by a local authority. We returned on 24 and 25 October 2016 to complete the inspection. Our inspection was carried out by two inspectors.

During our inspection we spoke with two people who lived at Towerhouse and one family member. We also spoke with two care staff and the registered manager. We made telephone contact with representatives from the local authority commissioning and safeguarding teams.

We spent time observing care and support being delivered in the main communal areas We looked at records, which included eight care records, three staff records and records relating to the management of the service.

Some people had complex needs so we used the Short Observational Framework for Inspection (SOFI) to observe the way they were cared for and supported. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection we reviewed information that we held about the home. This included correspondence, enquiries, records of previous inspections and information received from the local authority.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe at the home. One person said, "They look after me and keep me safe." A family member told us, "I think that [my relative] is much safer here than at home."

At our focused inspection of Towerhouse Residential Home on 3 and 10 June 2016 we identified that medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that medicines were not safely administered and recorded and there was no record of unused medicines that had been returned to the pharmacy. There were no trained staff members able to administer medicines in the absence of the provider/manager. In addition, there had been no audits of medicines held at the home.

We served a Warning Notice requiring the provider to take action to meet Regulation 12 by 27July 2016.

At this inspection we found that the provider had taken action to address some of our concerns. Medicines were administered safely and the provider/ manager and two staff members had received training in safe administration of medicines. There was a record of medicines returned to the pharmacy.

However, we identified the following failings. There had been no internal audits of medicines at the home despite this having been identified as a requirement at inspection and in the Warning Notice. Although a pharmacist had undertaken an audit in September 2016 this was not detailed. Medicine administration records (MARs) had not been completed to show that the medicines for people that were not contained in 'dossetts' provided by the pharmacy were counted and recorded. The MARs for people where prescribed creams and laxatives had not been signed to show that they had been administered. The provider/manager and a staff member told us that they did not know that they had to do this. In addition, the MAR and prescription for one person showed that a medicine had been prescribed to be taken every four to six hours. The MAR showed that this was recorded as only being given daily at 8.00am and 10.00pm. MARs for three people who had been prescribed pain relieving medicines to be administered every four to six hours as required were receiving these four times daily. There was no written guidance in place for staff on how and when to administer pain relieving medicines as required. We asked the provider /manager how staff knew that pain relief medicines were required. The provider/manager told us that for one person, if they were touched and they showed that they were in pain, medicines would be administered. However this was not recorded. We did not judge this to be a reliable method of pain identification.

During our inspection the medicines due to be administered to one person were left on top of the medicines trolley when the provider/manager was distracted by our arrival. These were immediately administered when we drew this to her attention. We also saw that the medicines trolley was left unlocked and unattended for approximately two minutes. The provider/manager immediately locked it when we pointed this out. We found prescribed creams for a number of people stored in a communal bathroom. When we raised this with the provider/manager the creams were removed and placed safely in people's rooms. A 'sharps box' had been purchased for the home. However this was stored on a shelf in the communal lounge area. When we pointed out that this was not a safe place we saw that it was immediately removed to a

locked office.

These concerns demonstrated a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the provider/manager about our concerns in relation to the management of medicines. She told us that she would take action to address these.

We looked at the care records for the eight people who lived at the home. There were no risk assessments in place for two people. When we looked at the care notes for these people we saw that in both cases behaviours such as trying to leave the home unsupervised and destruction of property had been recorded. However, there was no record that these risks had been assessed and that risk management plans were in place. Risk assessments were in place for the other people living at the home. Although there was a record of regular reviews, these had not been updated for over a year. We noted, for example, that one person was receiving treatment for a medical condition that impacted on their mobility. Their risk assessment had not been updated to reflect this.

During our inspection we observed that there were a number of risks associated with the environment. Following a serious incident, window restrictors had been installed to those windows which required them. However these did not meet the Health and Safety Executive (HSE) guidance on window restrictors in care homes. We brought this to the provider/manager's attention. She told us that these would be replaced and we saw an email from a specialist company confirming that this would be done on the day following our inspection.

When we visited the home on 20 October 2016 we observed that the carpet in the communal lounge was torn and presented a trip hazard. We pointed this out to the provider/manager and she showed us a letter confirming that replacement flooring had been ordered. When we returned to the home on 24th October we saw that the tear in the carpet had been taped to reduce the risk of trips. On 24th October we noted that plastic sheeting had been placed on a flight of stairs. This was wrinkled and could have caused a trip or fall. When we pointed this out it was immediately removed. The provider/manager told us that this had been placed on the stairs by contractors who were refurbishing a bathroom. We looked at this bathroom which was shared by two people. Although the doors from the bathroom to their bedrooms had been locked, the door from the bathroom on to the landing had been removed. We saw that the works were still in progress, the flooring was uneven and there was a cable protruding from the floor across the entrance. We drew the provider/ manager's attention to the fact that this could pose a trip hazard to people accessing the bathroom from the landing. She immediately arranged for the contractors to return and seal the exposed entrance.

A fire exit door to the side of the home through which a person had left the building was not adequately secured or alarmed. At our visit on 20 October we saw that it had been blocked by a small table which could have been moved by a person wishing to leave. When we returned to the home on 24 October we saw that a secure gate had been installed to prevent access to the street. However, the passageway outside the door led to a neighbour's garden which was covered in building debris which could have created a trip hazard. We discussed this with the provider/manager who told us that she would seek advice from the local fire safety officer regarding ensuring that the exit was secure and met fire safety regulations.

During our inspection we also found that a person had picked up a fire extinguisher and broken a window with it. Although the window had been replaced, the fire extinguisher was not securely attached to the wall. The provider/manager told us that she would ensure that a specialist fire safety company was called out to

ensure that fire extinguishers were made secure.

We saw that tests of fire alarm equipment had taken place and that safety certificates were in place for gas and electrical systems. However, there had been no recent checks of water or fridge/freezer temperatures which meant that people were potentially at risk of harm.

Although there was an environmental risk assessment for the home this had not been completed and did not fully address risk to people. For example, a section that had been completed stated that, "Residents in the house are all mobile." However, two people living at the home were receiving care in bed. Another person with a visual impairment was unable to move around the building unless supported by staff. There were no personal emergency evacuation plans in place for people. The concerns outlined above showed that there was a failure to identify, assess and manage risks to people living at Towerhouse Residential Home.

We also looked at infection control measures in place at the home. There was an infection control policy in place and we saw staff members using aprons and gloved where required. However when we asked to see an infection control audit, the most recent one available had been undertaken in 2010. We saw that there were faeces on the floor of a shared bathroom. The provider/manager told us that staff members cleaned the bathrooms regularly and we saw that this had been cleaned shortly afterwards. One person's room smelt of urine. We asked the provider/manager about this. She told us that this had been identified as a concern. We were shown a confirmation letter from a flooring company which showed that washable flooring had been ordered.

We saw, however, that cleaning materials and fluids were not stored in accordance with the Control of Substances Hazardous to Health (COSHH) 2002. These were stored on an open shelf in the kitchen area close to dried foods where there was a potential risk of cross contamination... Although the kitchen door was secured by a keypad, it was not always closed during our inspection which meant that there was a risk of people accessing harmful substances. The provider/manager told us that she would ensure that cleaning fluids and other materials were stored in a designated locked cupboard in future.

These concerns demonstrated a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 30 November 2015 we had identified issues in relation to the home's management of safeguarding of adults at risk. We did not assess this at our subsequent visit in June 2016 as there had been no safeguarding concerns in the interim.

During this inspection we found that the home had a detailed safeguarding procedure and the registered manager and staff member we spoke with were able to describe their responsibilities in relation to safeguarding. However two safeguarding concerns had not been notified to CQC and reports required by the local authority safeguarding team had not been completed. There was no safeguarding log maintained by the home and no record of safeguarding concerns recorded in people's files. This meant that we could not be sure that that safeguarding issues and concerns were managed safely.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were always two staff members working at Towerhouse during our inspection. Following our visit to the home on 20 October. the provider/manager told us that she would arrange for an agency worker to

provide one to one support for a person who kept trying to leave the home. When we returned on 24 October we saw that a third agency staff member was at the home providing this support. People did not have to wait for care and support. However we tested three call bells in people's rooms and found that the system was not working. We noted that there was no record that this was checked regularly. We raised this with the provider/manager who told us that she would arrange for the call bell system to be repaired or replaced as a matter of priority.

At our visit to the home on 20 October we asked to see the current rota for the home and the provider/manager told us that this had not yet been produced despite the fact that the week that would have been covered by the rota had commenced on 17 October. When we returned to the home on 24 and 25 October we found that a rota was in place but that this did not reflect the staffing arrangements that we saw. For example, staff members were working different shifts to those indicated on the rota. A one to one agency staff member who was working at the home was not recorded on the rota. When we raised this with the provider/manager she told us that she would ensure that rotas were maintained that were up to date and reflected the actual staffing at the home. We also asked the provider/manager how they assessed staffing needs at the home. We found that there was no staffing needs analysis or other system for doing so.

We looked at the recruitment records for three members of staff. We saw that two references had been received and that criminal record and barring checks had also been completed to establish that people were suitable to care for people living at the home. There were three care vacancies at the home and there was some reliance on agency workers to cover shifts. The provider/manager showed us that these posts had been advertised and a recruitment process was taking place. During our inspection a prospective new staff member visited the home to discuss the process of a criminal records check application.

Requires Improvement

Is the service effective?

Our findings

People told us that they had their needs met. One person said, "the do look after me." A family member told us, they have really supported [my relative]."

At our inspection of 30 November 2015 we found that there were gaps in the training records for staff and that regular supervision by a manager had not taken place. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our subsequent focused inspection in June 2016 we found that one staff member had not received training in mandatory areas such as safeguarding, moving and handling and food safety. In addition, regular supervisions had not taken place. We served a Warning Notice requiring the provider to take action to meet Regulation 18 by 27 July 2016. .

At this inspection we found that there remained no record that this staff member had undertaken core mandatory training. The provider/manager told us that this training had taken place. We asked to see copies of training certificates or other recorded evidence that confirmed this but these were not provided. We looked at the supervision records for three staff members. We saw that one staff member had received supervision in June 2016, but that two staff members had not received a recorded supervision session since February 2016. The records showed that they were due to receive further supervision during June 2016. However the manager told us that this had not taken place. In addition there had been no staff team meetings during 2016. This meant that staff members were not always receiving the appropriate training, supervision and support that they required to enable them to carry out their roles.

This demonstrated a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can 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 on authorisations to deprive a person of their liberty were being met.

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. The home had a policy on MCA and DoLS. However this required updating to reflect current guidance on DoLS. Staff members had not received training in relation to MCA and DoLS, although staff members that we spoke with was able to describe their responsibilities in relation to supporting people with limited capacity to make decisions.

When we looked at care documentation we found that information about capacity to make decisions was recorded for six people but there was no record of this for two people. There were no records that applications had been made to the relevant local authority team for authorisations in relation to the Deprivation of Liberty Safeguard (DoLS) for three people who were under continuous supervision and unable to leave the home unaccompanied due to risks associated with lack of capacity to make decisions. We asked the provider/manager about this. They told us that they would ensure that applications for DoLS authorisations for these three people were made.

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

Six of the eight care records that we viewed showed evidence of people's consent to the care that they received. The majority of care plans and risk assessments had been signed by the person receiving care or a representative. However, there were no care plans or risk assessments in place for two people and therefore we could not identify what care had been agreed and whether or not the person or their representatives had agreed to the care and support that they were receiving.

People's individual dietary and nutritional needs were met. There was a menu board on the dining room wall although this had not been updated to reflect the menus that were offered to people. We saw, however, that people were offered at least two choices at mealtimes, and that alternatives were provided if they chose to refuse these. We saw that food was taken to people who remained in their rooms and that a staff member stayed with them while they ate. People were offered hot and cold drinks and snacks throughout the day. People appeared to enjoy the food that they were offered and we saw that they ate well. One person that we spoke with told us that, "the food is great," and another person gave 'thumbs up' when we asked them about the food. The home maintained a nutrition and hydration record for each person, and we saw that these contained details of all food and drink that had been taken on each day.

The home undertook monthly assessments of people's risks in relation to nutrition using the Malnutrition Universal Screening Tool (MUST). We saw that these had been completed appropriately, and that guidance was in place for staff members to enable them to use the tool effectively. Although the records that we saw showed that people's weights were stable and within a healthy range, we asked the provider/manager about actions should a person gain or lose weight. They told us that this would be immediately referred to a GP for further assessment.

People's health care needs were met and monitored. Records showed that people regularly received health checks. They had access to a range of health professionals including; GPs, dieticians, opticians, chiropodists, psychiatrists, and dentists. They also attended hospital appointments.

Requires Improvement

Is the service caring?

Our findings

People spoke of being satisfied with the care provided at the home. Comments from people included; "I like the staff," and, "the are very caring to me." We observed that people appeared comfortable with their care staff and interacted with them in a positive manner.

Staff interacted with people in a respectful manner. We heard them ask people how they were, and saw that they checked on people's needs regularly. Staff members appeared knowledgeable about people's care needs. A staff member told us that, "We do try to keep up to date. People's needs change and it is important for us to know about this." However, when we spoke with a person who was living with dementia we found that they were eager to tell us about their background and provided us with details about the town where they grew up and their experiences as a child. This was a person for whom a care plan had not yet been developed and when we mentioned the conversation with the provider/ manager she told us that she was not aware of this.

People were supported to maintain the relationships that they wanted to have with friends, family and others important to them and the care plans that we saw included information about the relationships that were important to them. However two people did not have care plans and there was no record of their important relationships .During our inspection we saw that one person received a visit from family members. We heard staff speaking with visitors in a friendly manner. They provided family members with an update about their relative's condition.

We saw that, where people required personal support, this was provided in a timely and dignified manner. Some people chose to stay in their rooms or were required to stay in bed due to health conditions. We saw that staff members checked on their welfare regularly.

The provider/manager and staff members spoke positively about the people whom they supported. We were told, "this is the best place that I have worked at. It can be hard sometimes but the residents are lovely and it's really important that they get the care that the need."

People told us their privacy and dignity was respected. We saw that staff members offered people choices and ensured that they had the right support to undertake activities if they required it.

The care plans that we saw included information about people's health, cultural and spiritual needs. A faith representative visited the home regularly to provide worship for people to whom this was important.

Although the registered and staff members that we spoke with demonstrated that they understood the importance of confidentiality. We found that personal care documents for people were not always stored in a secure place. The provider/manager told us that she would arrange for a secure cupboard to be provided for these.

Some people's care files contained documented information about people's end of life preferences and

needs. This included information about whether people wished to remain at the home rather than being admitted to hospital. We saw that family members had been involved in supporting people with these decisions where required. The provider manager told us that these had not all been fully completed as some people did not wish to discuss their end of life preferences. The provider/manager told us the home had received support from the local palliative care team to support people requiring care at the end of life in the past, and that, wherever possible, all efforts would be made to enable people to remain at the home in accordance with their identified wishes.

Requires Improvement

Is the service responsive?

Our findings

One person who lived at the home told us that, "The staff are good. I don't have to wait for help."

We looked at the care plans for the eight people living at Towerhouse. The care files for six people were detailed and provided guidance of staff in how they should support people's needs. However, although there was a record that these had been reviewed on a monthly basis. they had not been updated since 2015. We noted that a person's physical condition had changed and that they were now confined to bed, but their care plan had not been updated to reflect this. Another person was receiving treatment requiring support from staff at the home but, again, this had not been recorded in their care plan.

Two people living at the home did not have care plans. One had been admitted to the home on 2 August 2016 and the other had been living there since 5 October 2016. We asked the provider/manager about this. She told us that she recognised that care plans needed to be in place, but had not completed these yet. When we looked at the notes of care for these two people, we found that in both cases there had been incidents associated with behaviour such as destruction of property and trying to leave the home unaccompanied. However care plans or risk assessments had not been developed to reflect these incidents and no guidance on managing behaviour had been provided for staff members.

Although the daily notes of care were detailed they we saw that the record books were full for two people and that there were no records for the week prior to our inspection. We asked the provider/manager about this. She told us that she had ordered new record books and was awaiting these. However she did not provide us with a record of daily care for these people that covered the gap. The lack of complete or up to date care plans and daily care notes meant that we could not be sure that people were receiving care that reflected their needs.

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

During our inspection people who were not in their rooms spent their time sitting in the communal lounge with the television on. Although staff members chatted with people we did not see any structured activities taking place. We asked about activities for people living at the home. We were shown an activities record that had been in use since 1 September 2016. This showed that activities had included seated exercise, local walks and hand massages and nail painting for female residents. We saw that an entertainer came to the home on Wednesday afternoons to involve people in music sessions. There were books and DVDs available at the home, but these were not easily accessible to people unless they were taken out of storage by staff. We spoke with the staff member who took the lead on organising activities. She told us that she recognised that activities at the home were limited, and that she was looking to increase the range offered to people.

We noted that most people's rooms were sparsely furnished and did not include many personal items. One person at the home liked music but did not have a radio or music player that they could listen to. There were no personal televisions or radios should people wish to be entertained if they decided to stay in their rooms.

For example, one person at the home liked music but did not have a radio or music player that they could listen to.

We did not see records that showed that people were consulted about or involved in making decisions about the home. Although there were records of resident's meetings having taken place during 2015, there were no such records for 2016. This meant that we were unable to ascertain if people had been consulted about, for example, menus, activities or changes to the home such as the refurbishment of bathrooms that were taking place. We spoke with the provider/manager about this. She told us that people were consulted with but acknowledged that there was no record of this.

The home had a complaints procedure. One person told us that, "I will tell the manager If I have a complaint." A family member said, "I've no complaints but I know what to do if I have," We looked at the register of complaints maintained by the home and saw that there had been no complaints.

Inadequate

Is the service well-led?

Our findings

We saw that the provider/manager worked shifts at the home and that people and staff members were familiar with her. One person told us, "I like her," and another said, "She is good to me."

When we inspected the home on 30 November 2015 we found that the provider/manager had failed to notify CQC about a safeguarding concern. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. When we returned to undertake a focused inspection during June 2016 there had been no notifiable incidents. However, at this inspection we found that the provider had again failed to inform CQC about two recent incidents that required notifications under these regulations.

This demonstrated a continuing breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We discussed this with the provider/manager who told us that she would submit notifications in relation to these incidents.

We looked at systems to monitor the quality of the service provided at the home. Although there were systems in place these had not been followed and we found that the provider/manager had failed to take sufficient action to assess, monitor and improve the quality and safety of the service provided.

We found that there were no recent completed internal audits in relation to medicines, health and safety and infection control. We were shown copies of pressure ulcer audits and care plan audits. The audits identified who was at risk of developing pressure sores and who had a care plan but the audits did not cover the quality of records, identify concerns or how they would be addressed. The audits did not identify that two people did not have care plans or risk assessments. When we looked at people's care plans and risk assessments we saw that they had been reviewed on a monthly basis, but they had not been updated to reflect changes in people's needs.

We reviewed the policies and procedures.in place at the home. Apart from the policy in relation to DoLS which required updating, these were up to date and reflected good practice guidance and regulatory requirements. There was a process in place to ensure that staff members were required to sign when they had read the policies. However we found that the provider/manager had failed to follow a number of these policies and procedures, for example in relation to care planning and risk assessment, health and safety, medicines, infection control, staff supervision and training. Our review of records and our observations of the home environment during this inspection showed that there had been a failure to identify and assess risk to people living at the home.

We asked about how the home obtained feedback from service users and other stakeholders. The most recent satisfaction survey had taken place in 2014. The provider/manager told us that informal feedback was obtained from people but there was no record of this nor how such feedback had been acted on.

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

During the time of our inspection the provider/manager was covering staff shifts. We saw that she worked effectively with other staff members on the shift and communicated in a positive manner with the people living at the home.

Staff members told us that they felt supported by the provider/manager. We were told that, "She's brilliant. I feel very well supported." The provider/manager did not have a designated deputy to provide management support if she became unwell or needed to go away. Although she told us that she lived next door to the home and was always on call, we were concerned that that there could be issues in relation to continuity of service if she was unavailable for any significant period of time. She told us that she recognised that this was an issue and that she was planning to recruit to the vacant position of deputy manager.

Records showed the home worked well with partners such as health and social care professionals to provide people with the service they required. Information regarding appointments, meetings and visits with such professionals was recorded in people's care notes.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out assessments of the needs and preferences for care and treatment of service users. 9 (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to make applications for DoLS authorisations for people in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have systems in place to demonstrate that actions were taken to prevent and deal with abuse. 13 (1) (2)