Venetia Residential Care Home Limited

Venetia Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 16 August 2016. The inspection was unannounced. Venetia Care Home is a care home registered for a maximum of eleven adults who have mental health needs. At the time of our inspection there were nine people living at the service.

The service is located in two large adjoining houses, one located in Venetia Road, the other Lothair Road, on two floors with access to a back garden.

We previously inspected the service in September 2014 and found that the service was meeting all the requirements inspected.

At the time of the inspection the registered manager was on holiday so we met with the care workers who were working at the time and spoke with the registered manager on her return from holiday. 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.

Whilst we witnessed some kind interactions between care staff and people living at the service we had a number of concerns in relation to cleanliness of the service, the level of staffing and practices that were not respectful of people's privacy or dignity. We were also concerned the provider was restricting people's access to their cigarettes and the kitchen without written agreement either by the person or the person acting on their behalf, if they didn't have capacity.

Food in the fridge was not labelled with use by dates so that people knew when it must be eaten by, and the house on Venetia Road was not clean throughout. Since the inspection the registered manager told us the service has been deep cleaned and food is now labelled and stored hygienically in the kitchen.

Staff told us there were always two staff on duty in the day, but we found the rota routinely showed only one staff member on duty on weekend mornings. When staff went on holiday we found two occasions when the registered manager did not replace them so this meant there were less staff available to support people. This meant people were at risk of their needs not being met.

People told us there were very limited resources for activities at the service and we could only find one game and some music CD's. Since the inspection the registered manager told us they have purchased games and books which were locked away when not in use to minimise damage.

People told us the kitchen was locked outside of meal times so they could not always get drinks or snacks when they wanted.

We saw from records that supervision was not regularly taking place with staff and training was limited. People had not been trained in understanding mental health needs since 2011 and had not received training in managing people's behaviours. This affected the staff's ability to understand and meet people's needs. Since the inspection training in mental health needs has taken place and the registered manager told us supervision is now taking place regularly.

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).

Neither the staff nor the registered manager understood the requirements of the MCA or DoLS. This meant they were restricting people's liberty without any awareness of doing so. The registered manager as a result of our intervention, has since applied for assessments for DoLS for three people living at the service.

Whilst staff could tell us about safeguarding, we were aware from discussion and the lack of action in relation to a recent specific incident that safeguarding issues were not always identified by staff and acted upon. This meant people may be at risk of abuse.

At this inspection we saw that the décor was poor in one of the houses and a shower room had been closed for use.

There was an absence of quality monitoring systems in place for key areas to ensure regular supervision and training took place and care records contained documents relating to consent. Where systems were in place some of these were deficient, for example, the cleaning log. This meant that the quality of care was not properly monitored.

There were no complaints logged in the last 12 months.

Management of medicines was safe, and recruitment practices were safe. Relatives told us they were satisfied with the care provided, found staff caring at the service and appreciated the structured environment provided for their family members.

We found the provider was in breach of standards relating to the safe care and treatment of people using the service, safeguarding people from abuse and supporting staff through supervision and training. The provider was also in breach of standards relating to person centred care and dignity and respect. Lack of consent for restrictive practices and lack of effective quality monitoring systems meant there were further breaches of standards in relation to governance of the service and consent. We are considering our regulatory approach and will report on this further when complete.

We have made a recommendation in relation to the environment of the service, and in relation to making the complaints process accessible to people living at the service.

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. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

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

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 always safe. Safeguarding processes were not followed so people may be at risk of abuse.

There were not enough staff to provide care safely to people.

Risk assessments did not cover all the risks identified so staff had insufficient guidance to support people safely.

Recruitment practices were safe and medicines were stored safely.

Is the service effective?

Inadequate

The service was not always effective. There was insufficient supervision and training for staff to support them in their role.

Staff and the registered manager had limited understanding of the MCA and DoLS, resulting in people being restricted without necessary procedures or agreements in place.

People had access to healthcare as they needed it.

Is the service caring?

Requires Improvement

The service was not always caring. People were not provided with person centred care as there were examples of restrictive practices negatively impacting on all the people at the service.

People's medical conditions were discussed in front of them in a way that lacked respect for their dignity.

We witnessed kind interactions between some staff members and people living at the service.

Is the service responsive?

Requires Improvement

The service was not always responsive. There were few resources or activities for those unable to regularly go out.

There were no complaints logged despite the people at the service being unhappy in relation to certain practices.

Relatives told us they felt confident that issues raised would be dealt with by the registered manager.

Care plans covered a wide range of areas and had been completed in the last 12 months.

Is the service well-led?

Requires Improvement

The service was not well led. There were few quality audits in place to ensure the service was of a good standard.

Some key policies were generic. This meant they were either not relevant or followed by the service.

Venetia Care 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 16 August 2016 and was unannounced.

The inspection was carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service including notifications received from the provider. CQC requires that certain incidents, events and changes that affect a service, or the people using it are notified to CQC as notifications.

During the visit we spoke with four people living at the service. The other people living at the service either chose not to talk with us, or we were unable to communicate with them verbally. We inspected all communal rooms and looked in five bedrooms.

We spoke with two support workers at length and the proprietor briefly.

We looked at the five people's care records and risk assessments. We looked at three staff recruitment files and training records. We looked at supervision records for all the staff.

We looked at the systems for managing medicines and for managing people's money. We checked documents related to the maintenance of the building, the accident/incident folder and meeting minutes related to staff discussions and meetings for people who live at the service.

Following the inspection we spoke with the registered manager and three health and social care professionals. We also spoke with two relatives. The registered manager also provided us with additional information in relation to training, and DoLS.

Inadequate

Is the service safe?

Our findings

Three people living at the service told us they felt there was not enough security as items had gone missing from their rooms. One said, "We don't call the police as we don't know who it is and we've left our room door open." People told us that during the weekend preceding the inspection visit a person had lost their wallet with money in it. The person was not aware of any action taken by staff in response to this theft. The registered manager told us each person had a lockable box for secure items in their room.

Staff were able to tell us the different types of abuse that can occur and were aware of their obligation to make the manager aware of any concerns they may have in relation to safeguarding adults. They were also aware of whistle blowing. However, when we asked one of the care workers about the incident regarding the allegation of theft the previous weekend we were told that staff had looked for the wallet and found it two days after it had been reported missing. The money the person said had been in it was not found.

We asked if the incident had been recorded or investigated. The care worker told us that it was not clear if any money had in fact gone missing. As a result no paperwork had been completed nor did the care worker consider this to be a possible safeguarding issue. This was of concern as good practice would be to investigate the allegation of theft within the service in the first instance, and a referral made to the appropriate authorities if there were safeguarding adult concerns. . We asked the care worker if they were aware of the process to alert the local authority regarding a safeguarding issue. They told us they were not aware of it.

Following the inspection we spoke with the registered manager regarding this incident. She reported that the money was found five days later in the drum of the washing machine with an item of jewellery. However, she acknowledged that the incident had not been formally recorded at the time and that there was no recording to support other instances where people had reported belongings had gone missing.

We noted the safeguarding policy did not contain any information for staff on the procedure to follow if a safeguarding issue arose, nor did it refer to the role of the local authority or CQC. There was no information with regard to the form to complete to alert the local authority or who to send it to. We spoke with the registered manager in relation to the generic nature of the policy. She undertook to review this policy.

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

Some parts of the premises were not clean. Cupboards in the kitchen at Venetia Road were not clean. Potatoes and onions were stored in containers that were visibly dirty, there were cobwebs in a number of areas throughout the service including the ceiling of the kitchen seating area, and paintwork was dirty.

Food in the fridge was not labelled or sealed effectively. This included packets of ham and cheese. Food had been frozen without being date labelled which meant staff were not clear when it had to be used by. We saw a care worker using the same plastic beaker to give water with medicines to more than one person living at

the service.

These issues were of concern as they placed the people living at the service at risk of infection.

Since the inspection the registered manager told us they are now labelling food and storing it hygienically, and that the service had been deep cleaned.

Staff had completed recent risk assessments. We noted that not all issues identified on care plans were noted on risk assessments. Nor did all risk assessments have information for staff on how to manage or minimise all the risks. For example one risk assessment noted a person could become aggressive if they were refused money, but the suggested action for staff was training in behaviour management and restraint instead of guidance on how to minimise the risk of aggression. No training in diffusing aggressive behaviour had taken place.

We also noted a serious incidence of self-harm on one person's notes at a key worker session but this was not noted on the risk assessment. This was of concern as there was no guidance for staff as to how to identify and manage this behaviour should it be repeated. Another person's risk assessment noted a person had issues with over eating but the risk assessment did not note the kitchen door was locked as a result. The risk assessment for another person noted they would receive counselling around the health issues related to smoking when in fact one of the ways the service managed their cigarette use was to ration them.

These issues were of concern as staff did not always have written guidance as to how to manage specific risks, and there were instances where the risk assessments did not accurately reflect actions the service were taking to manage risks to people's health, safety and wellbeing.

The above concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were concerned to note from staff rotas that whilst the rota stated there were two people to be on duty in the day and one person sleeping in, annual leave for a staff member had not been covered on two occasions in the period from 25-31 July, and 15-21 August. We also noted from the rota that routinely on Saturday morning from 9-11am there was only one person on duty and on Sunday from 9-2pm one person on duty.

Reduced staffing was of concern as one person living at the service had significant needs and behaviours that can challenge and their care plan stated "staff to always monitor [person's name] whereabouts." The lack of staff also meant that staff were unable to provide individualised care to other people living at the service and placed people at risk of harm. As staff could not leave the service unstaffed, when there was only one staff member on duty those people who needed staff support to go out would not be able to go.

The above concern was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records for the management of money. We could see that people signed for receipt of their money which was good practice.

We could see that recruitment practices were safe. Two references were in place for each staff member and staff records had Disclosure and Barring Service certificates and proof of identification. In addition, records contained evidence of the right to work in the UK where needed. These checks minimised the risk of

unsuitable people being employed.

Medicines were stored safely and accurate records were kept of administration.

All of the essential equipment, for example, gas and electrical installations and fire equipment, were serviced in the last twelve months, or within timescales recommended to ensure the building was well maintained.

Inadequate

Is the service effective?

Our findings

We looked at the supervision records for care staff. We found that only one member of the care staff was supervised on a regular basis. This person had received supervision four times in 2016. We saw that one member of the care team had not received supervision since 2013, the other since 2014. The cleaner had been supervised regularly in 2014 up until March 2015. There were no records for another staff member who was a family member on the staff rota.

We discussed this with the registered manager. It was acknowledged that supervision had not taken place for the majority of staff. She told us that it was difficult to offer supervision to a staff member who was a family member, but there were no other records to reflect that discussions had taken place to discuss training needs raised by this family member or other staff. The registered manager could not explain why the other non-family care staff had not received supervision. A lack of supervision meant that staff may not be supported to carry out their role effectively and may not have opportunity to discuss their work and any areas for learning.

We looked at staff training records. For one person who regularly worked at night we noted they had attended training in a number of areas in 2016. These courses covered areas such as office safety, manual handling, slips trips and falls and role of fire warden. They had received training in managing medicines in 2014 and safeguarding adults in 2015. However, we noted this person had never received training in working with people with mental health needs or behaviours that challenge.

For two other members of the care team they had last received training in understanding mental health needs in 2011, but had not received any training in managing behaviours that challenge. Training in safeguarding and administration of medicines had been undertaken in 2015 and 2014 respectively for both staff. Health and safety, fire safety and first aid had taken place in 2012 and 2013.

The policy on training stated that in house training would take place in key areas including managing aggression and violence, and understanding of different types of mental illness. Apart from the training in mental illness awareness in 2011, we could not find any records for additional training. There was also no time frame stipulated for training or refresher training.

None of the care staff had received training in food hygiene since 2011. Lack of supervision and training was of concern. Staff need skills and knowledge to care safely for people and to understand their obligations to the people they care for. From talking with staff members and the registered manager we were concerned that some staff had little understanding of mental health issues, had received no training in managing behaviours that challenge despite two people living at the service having such behaviours. Staff also had very limited knowledge regarding issues of consent, and of safeguarding. Staff told us they had received some training and one staff member confirmed they had regular supervision.

The above concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the registered manager has applied for distance learning courses in mental health for seven staff, and staff have attended training on the MCA.

The 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 on authorisations to deprive a person of their liberty were being met. There were no DoLS in place despite three people not being allowed to leave the premises on their own and being under continuous supervision. Following discussion with the registered manager, she agreed that applications for DoLS were required, and has subsequently applied for these. The registered manager has also told us she has updated risk assessments to acknowledge DOLS have been applied for.

We also noted that restrictive practices were in place at the service and appropriate processes had not been followed for all people living at the service to legitimately restrict people's access to the kitchen, to their cigarettes or to their money. This applied to people with and without the capacity to make decisions. Where a person had been assessed as not having mental capacity to make a decision then a best interest decision should be made on their behalf and documented. This had not taken place.

The majority of the people living at the service smoked cigarettes. Staff told us that some of the men would become distressed if they ran out of cigarettes, or were unable to know if they had just smoked a cigarette so they would smoke another one, 'chain smoking'. To counteract this staff restricted five people's access to their cigarettes. Staff told us these five people were given a cigarette every 45 minutes in the day time. We did not find any records on files where people had agreed to this arrangement. We asked a member of staff if they were aware of written agreements by people to this arrangement. They said no. We asked them to check the care records for three people to confirm this. They could not find any written agreement. Staff supported two other people to manage their cigarette intake. Another person smoked as he wished.

We spoke with the registered manager who acknowledged the most restrictive practice of giving cigarettes every 45 minutes had become a practice without formal agreement. We found the same to be the case with a person whose access to funds was also limited. One family member told us they were glad the office managed their relative's money as they were at risk of exploitation due to limited mental capacity.

We noted some of the people living at the service may have needed support in managing their money or cigarettes, but it did not appear best practice procedures had been followed to ensure this process was for the benefit of the people living at the service. For example, one person told us "We are told at the table you can't have cigarettes because you are eating too fast or because you need to change your socks."

We noted there was a sign on the wall stating 'Kitchen opening times for tea, coffee, hot milk, hot chocolate, Ovaltine or juices: 9-10am with breakfast, 12-1pm with lunch, 3pm, 6pm, 8-9pm". We asked staff about this and were told the kitchen was kept locked for significant parts of the day as some people were at risk of overeating which resulted in them being sick. One family member confirmed this was accurate and was part of her relative's mental health condition. Of five care records we looked at three people had issues with

food. Only one person had signed to agree to the kitchen being locked. We were told by staff that some relatives had signed to accept this policy but in the absence of mental capacity assessments there was no evidence that they had authority to agree to this policy.

The above concerns were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Only one person had received training in MCA or DoLS in 2011. When we asked two members of the care staff what they knew about the MCA, neither of them were able to tell us, although they both understood about the need for consent to provide personal care and the need to provide choices for food. The registered manager acknowledged she had little knowledge in relation to the MCA or DoLS. Since the inspection the registered manager has applied for DoLS for three people living at the service as they were being deprived of their liberty by not being able to leave the premises unaccompanied.

The above concern is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of the inspection we saw people had sandwiches for lunch, and a family member of the proprietor who was not a rostered member of the staff team cooked a meal that looked appetising for dinner that night. We also saw in the fridge that a specific dish had been cooked by a member of the care staff as some of the people living there were either Greek or Cypriot and enjoyed Greek food. A family member told us she thought the food was good. We saw that there was a four weekly menu that rotated and we were told people had a chance to influence what was on it. People could get access to food and drink at specific times in the day.

People living at the service did not comment on the food but one person told us "The kitchen we used to have it but another resident used to go and eat the cheese and tomatoes eat half chuck half. We have had to suffer because of him." There was no acknowledgement by the provider that this policy of the kitchen being closed affected other people at the service. This practice was not person-centred.

We noted that in the house on Lothair Road there was no food or provisions to make a drink of tea, coffee or cold drink, despite there being a fully equipped kitchen. We were also told that the person who lived in this house could make hot drinks for themself. We asked the care staff why this was the case on the day of the inspection. They did not know. We also asked the registered manager about this after the inspection. She did not have any explanation for there being no provisions in the house.

The above concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could see from care records that people had contact with medical professionals on a regular basis including the dentist and optician. People's family members told us they thought the service supported people's health needs well. One health and social care professional told us that the service had worked well with one person when they first arrived to address their behaviours. This was positive. Some of the people were able to tell us about their health conditions and their medicines.

Requires Improvement

Is the service caring?

Our findings

One person told us "The staff are alright [named four staff members], sometimes I argue with [staff member]." During the inspection we witnessed good staff interaction with people living at the service, for example, having a joke and offering tea in a respectful manner. One family member told us she thought staff were kind to her relative, another family member told us they have to "have a routine with [relative's name]." People living at the service told us there were no fights or violent incidents at the home between the people living at the service, which was positive for all.

We also witnessed interactions that did not show sufficient respect for people living at the service. For example we witnessed a staff member calling people to come to the office to have their medicines by shouting their name loudly from the office. The people requiring medicines took it in turn to enter the office. As the office opens onto a small yard which is bordered by a road, people walking in the road would be able to hear this practice. One person told us "Medication, we all have to take it at the office not in our rooms." Another person told us "We go to the office for medication and a cigarette all together." We discussed this with the registered manager who told us people had never asked to have their medicines in their room.

One person told us about a staff member's attitude "it's terrible. On a personal level you just can't reason with [staff member]." Another person told us "They are a bit strict about smoking, not getting up a certain time. You go down to the lounge, you have to tell them where you are going all the time even if you go out for 10 minutes." We witnessed a staff member shouting out loudly to people from the service as they were walking down the road, asking them where they were going. This practice did not respect their dignity.

On looking around the premises we noted one bathroom was locked. We asked the staff member to open the door and saw the hose was removed from the shower, and there was a laundry basket in the room, blocking access to the toilet. The staff member told us that due to the behaviour of one person the room was not used as this person turned on the taps and the floor had been flooded on a number of occasions. This meant there were less washing facilities for the people in the house to use. We discussed this with the staff member and with the registered manager after our visit. We noted there had been no alternative solution considered other than to close off the room entirely. There was no acknowledgement of the impact this had on other people living at the house, as this was the only step in shower in the house, the other was above a bath.

The closure of the room, along with the locking of the kitchen demonstrated a lack of person centred care practices by the provider. This meant that as one person had behaviours that were at times destructive, the environment for everyone was affected and the solution was disproportionate to the problem.

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

When we talked to staff about dignity and respect, staff were able to tell us how they knocked before entering people's rooms, and were mindful of dignity issues when supporting them with personal care.

A person told us "[staff member] has no taboo and lacks insight when it comes to people." We witnessed a staff member talking about people's confidential health conditions and behaviours in front of them on two occasions in a way which lacked respect for their dignity. We also noted on the minutes of a residents' meeting, which had been chaired by the registered manager that people's health conditions and side effects of medication has been discussed openly in front of other people living at the service. This was a lack of respect for people's privacy.

We saw that people were weighed regularly up until April and May 2016. A person living at the service told us "We get weighed just outside the office." This was a public area in the yard with a low wall bordering the road, so would afford very little privacy.

The above are examples of poor practice from staff on the day of the inspection which clearly had become embedded as 'normal'.

The above concerns were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The house on Venetia Road was not in a good state of decor. We discussed this with the registered manager who told us the provider planned to redecorate the service in the summer of 2017.

Despite the majority of the men smoking cigarettes, there was no covered place for them to smoke outside in the bad weather.

We recommend the provider seeks the views of people living at the service to make improvements to the environment both inside the premises and in the yard.

People's bedrooms varied with the level of personal effects in them through choice. People were able to have visitors but there were prescribed times on a notice. However, staff told us people could come at any time. There were lots of notices with rules on the walls in the dining area.

The registered manager told us they obtained the views of people living at the service through residents' meetings and key worker sessions. We saw both of these did take place on a regular basis. Some care records had people's signatures on them indicating they had read and agreed to them whilst others did not.

There was no-one living at the house with specific cultural requirements, but we could tell from talking with one staff member and the wife of the proprietor that the service prepared Greek meals that many of the people enjoyed as they were from Greece or Cyprus.

Staff encouraged people to carry out their own laundry and clean their rooms or assisted them to do so where necessary. Care was provided in a way so people were not encouraged to improve their cooking or kitchen skills to become more independent. This was not identified as a concern by the people living at the service.

Requires Improvement

Is the service responsive?

Our findings

Care plans had been completed within the last 12 months. They covered areas such as independent living, personal skills, relationships and family network, communication and health. They provided detailed information about people's needs. They also contained personal historical information where this was available.

Staff told us that some people attended a Mind Day Centre two days a week. Some people were able to come and go as they pleased. They had their own friends or family to visit or put a bet on at the local betting shop.

We noted that for others who could not go out alone there were few activities planned. There was also very few resources at the service. There was a game of skittles and some CDs to play music, although people told us they played Connect 4 sometimes. One staff member played guitar as did a person who lived at the service. On the nights when this staff member slept in at the service, they would sometimes play their instruments or sing together. However, there were no books or DVDs in the living rooms. Staff told us that one person had damaged resources which explained why there were so few at the service. A family member told us their relative was liable to damage goods including TVs and mirrors. There were two TVs in the living rooms to enable people to watch different programmes if they chose.

We discussed this with the registered manager who told us that often people at the service did not want to participate in planned activities and that resources had been bought in the past but had been damaged. Following the inspection the registered manager told us more resources had been bought and were now locked away when not in use to minimise damage.

Family members told us their relatives were unlikely to get particularly involved in activities, but one relative said maybe the service could arrange more days out.

We saw that many of the men got on well with each other and there was a friendly atmosphere between some of the staff, people living at the service and the proprietor.

We asked staff how they dealt with complaints from people living at the service. They both told us they would tell the manager. We couldn't find a complaints book at the service. We asked the registered manager if there were any complaints in the last 12 months. She was not aware of a complaint in this period. Family members told us they felt confident the registered manager would address any issues they raised.

We discussed the lack of complaints by people living at the service with the registered manager and questioned whether the people living at the service were aware of the complaints procedure or considered their complaints would be taken seriously. The registered manager told us the keyworker sessions were a chance for people to air their complaints. However, through discussion the inspection team became aware of issues raised by people living at the service they were not happy about.

We recommend the provider consider how to ensure the complaints process is fully accessible to people living at the service.

Requires Improvement

Is the service well-led?

Our findings

On the day of the inspection the registered manager was on holiday. We asked to speak to the person in charge, in particular the proprietor as he was working a shift that day. For a variety of reasons he was only able to speak with us briefly and said we needed to speak with the registered manager on her return, which we did. On another occasion when the registered manager was on leave we phoned to gain information. It was not entirely clear who was in charge in the registered manager's absence. We have since discussed this with the registered manager who told us that the proprietor is responsible for financial issues and dealing with any urgent issues, whilst a care worker is aware of paperwork and care records when she is not available.

We could see from the records on the wall in the office that there was a kitchen cleaning schedule in place for each week although there was none for the month of July 2016. We asked the registered manager what quality assurance processes were in place to check cleanliness as we found the service at Venetia Road to be in a poor state of cleanliness. The registered manager acknowledged the cleaning was not of a good standard and undertook to carry out a deep clean. The registered manager initially thought the requirement to label food when opened was too onerous as it was used quickly but we explained that it was best practice to ensure food safety. The registered manager undertook to ensure staff labelled and covered food once it was opened.

We asked the registered manager what other quality assurance processes were in place. She told us that the medicine cabinet and stocks were checked on a three monthly basis, and records confirmed this. We could also see from records that a fire risk assessment of the whole service had been undertaken in January 2016. The registered manager also told us she updated the care records every 6-12 months and reviewed the policies yearly.

We found that the policies were not always specific enough to be helpful, for example the safeguarding policy, or they were not adhered to, for example the supervision policy. The registered manager had no system to check the quality of the service offered by the staff. There was an absence of quality monitoring systems in place for key areas to ensure regular supervision and training took place and care records contained documents relating to consent. Elements of poor practice had become embedded as 'normal' due to the lack of audits and quality assurance processes.

Although the 'Policy on Quality Management' referred to gaining the views of stakeholders and people living at the service, there was no evidence of seeking and acting on people's views on the service in an effective way.

People's historical care records were not stored securely. They were in folders in a room used for undertaking laundry. On the day of the inspection this room was open from our arrival at 8.45am until 2pm. During this time people living at the service and the domestic staff had access to the room. This meant people's confidential information was not stored safely or securely.

The above concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager told us she had had lockable cupboards placed in the laundry room to store historical files securely.

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 service did not take into account people's preferences when meeting their needs. People were not offered the choice to take their medicine in their room. People were publically asked where they were going when they were leaving the premises. Meal times were set and the kitchen was closed outside of set times. There were no provisions to make hot or cold drinks at Lothair Road and one bathroom was closed off for use as a solution for one person's behaviour. Regulation 9 (1)(2)(3)(a)(b)(f)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect We witnessed a staff member discussing a person's health condition and behaviour to another person in front of them. Meeting records showed the registered manager discussed a person's health condition in a residents' meeting. People were weighed in an area where the public could see and this was demeaning. Regulation 10(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Restrictive practices in relation to managing cigarette intake, one person's money and access to the kitchen were in place without necessary documentation to support the

practice. Regulation 11(1)(2)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks were noted on risk assessments. Not all risk assessments had information for staff on how to manage or minimise all the risks. Some risk assessments did not reflect actions the service was taking to manage the risks. People who use the service were not protected from the risks of infection, due to ineffective cleaning and food hygiene processes in place. A staff member used the same cup to provide water to more than one person to take their medicines. Regulation 12(1)(2)(a)(b)(h).

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 Missing items were not investigated as possible theft and safeguarding procedures were not followed by the service. People were being deprived of their liberty without DoLS in place. Regulation 13 (1)(2)(3)(5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure there were systems or processes in place to assess, monitor and mitigate the risks to the health, safety and welfare of the people living at the service. Confidential historical care records were not stored securely. Regulation 17(1)(2)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff on duty

to provide safe, quality care to people living at the service on two occasions when staff were on leave and routinely for periods of time at the weekends. There was insufficient supervision and training for staff to support them in providing good quality care. Regulation 18 (1)(2)(a).