TM & TR Ltd

Harewood House

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

This inspection took place on 25 August and 2 September 2016. The first day of the inspection was unannounced, and the second day of inspection was announced.

Harewood House is registered to provide accommodation for up to 29 older people, almost all of whom are living with a dementia or a dementia related condition. Many of the people at the home live with an advanced dementia and have specialist needs relating to their behaviour and wellbeing. Accommodation is provided over two floors and there were 22 people living at the service when we inspected.

The home did not have 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.

At the last comprehensive inspection of this service on 21 April 2015 shortfalls were identified in relation to infection control. At this inspection, the registered provider had made improvements to infection control practice and the service was no longer in breach of this regulation.

The provider had not ensured staff followed their missing person's policy and procedure and had therefore not ensured that people were protected. Risk assessments did not provide sufficient guidance for staff to offer care which protected people from harm while maximising their freedom.
People were not adequately protected from abuse and avoidable harm.

Staff were not receiving adequate supervision and appraisal to support them to offer effective care.

The service was not responsive to the needs of all the people who used the service.

Care planning did not sufficiently address people's detailed needs in relation to all areas of their care and wellbeing.

The manager had not received an adequate induction process to their role and had been left to manage the service without sufficient induction or support. This had led to a number of concerns including the placing and appropriateness of admissions to the home.

The registered provider had not informed CQC about safeguarding incidents or other events which they are required to do by law. We found they did not have effective auditing procedures in place to ensure they had the information needed to monitor and plan improvements.
Effective and safe systems and processes to ensure compliance with legal requirements and to keep people safe were not in place and governance of the service was inadequate.

Medicines were safely handled to protect people.

Staff were able to tell us what they would do to ensure people were safe within the home. The home had sufficient suitable staff to care for people and staff were safely recruited. The environment of the home was safe for people.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date across a range of relevant areas and the manager planned to improve this further with a range of face to face training to supplement the e-learning already offered.

Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They understood that people should be consulted about their care and understood the principles of the MCA and DoLS. People were not fully protected around their mental capacity because mental capacity assessments were sometimes not sufficiently detailed to give staff appropriate guidance.

People's nutrition and hydration needs were met. They enjoyed the meals which were of a good quality. Specialist advice around people's health care was sought and followed.

Some people had not received a caring service when they had left the building without staff noticing, or when a person was inappropriately admitted to the home. However, most people were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with dignity and respect. Staff had knowledge and understanding of people's needs and worked together well as a team.

Records and observations provided evidence that people were treated in a way which encouraged them to feel valued and cared about.

People were supported to engage in daily activities they enjoyed and which were in line with their preferences and interests. However, they did not often have the opportunity for outings.

People told us their complaints were responded to; however there were no records of complaint investigations as the acting manager told us that there had been no formal complaints. Visitors told us that if they had concerns they were always addressed by the manager who responded quickly and with courtesy.

The manager had recently taken on their role. Visitors and health and social care professionals told us the manager was approachable and supportive of staff. The manager responded positively to the inspection process and was open to improving their practice. They told us of a number of plans they had for improving the service around care plans, risk assessments, care reviews, the quality and scope of audits, infection control, and updating policies and procedures. They were also planning to consult more effectively with people, their representatives, and professionals who were involved in people's care.

We identified multiple breaches of regulation relating to person centred care, safe care and treatment, governance of the service and staffing. We also identified offences in relation to failure to notify and the provider's statement of purpose which we will follow up separately. You can see the action we have taken at the back of this report and we will be pursuing all of these matters directly with the registered provider.

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.

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.

Risks to people's safety were not thoroughly assessed and risk plans did not provide staff with sufficient guidance to manage risk safely or effectively.

People had gone missing from the home without staff being aware, which placed people at risk of serious harm.

Sufficient staff were employed who were safely recruited. Medicines were managed correctly.

Improvements had been made to ensure people were better protected from the risk of cross infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were supported in their role through training, however they were not well supervised which meant they did not have all the support they needed to provide good care.

Visitors told us that people were well cared for and that staff understood their care needs.

The service met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA).

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were skilled in clear communication and the development of respectful, caring relationships with people. However, some staff had been neglectful of their duties which had led to people

being placed in distressing circumstances.

Staff had respect for people's privacy and dignity.

People received compassionate and appropriate care when they reached the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

The service had not assessed or responded to all people's care needs in a holistic way which meant for those people that their needs were not being fully met.

People had access to activities which were of interest to them, however people rarely went out of the home and the range of activities on offer for people was limited.

The home had signage to support people to find their way around.

People's concerns were listened to and acted upon.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in place.

The provider's quality assurance systems and records were inadequate which meant they could not effectively monitor the safety of the service or plan improvements.

Notifications were not being sent to CQC as required which meant people were placed at risk.

The provider had not adhered to their own statement of purpose.

Staff and those we spoke with told us the manager was approachable and acted on their suggestions.

Harewood 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 registered 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 25 August and 2 September 2016 and was carried out by one adult social care inspector. The inspection was unannounced on the first day and announced on the second.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. We did not ask the registered provider for a Provider Information Return (PIR) this is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. Provider Information forms are sometimes not requested to coincide with inspections which need to be rescheduled for operational reasons. We gathered the information we needed during the inspection visits.

During the inspection visit we spoke with four people who lived at the home, two visitors to the service, three members of staff, the manager and the assistant manager. After the inspection visit we gathered information from three health and social care professionals and two health care professionals.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at all areas of the home, including some people's bedrooms. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at four sets of care records and associated documentation. We examined records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the records for three members of staff. We also observed the lunchtime experience and interactions between staff and people living at the home.

Inadequate

Is the service safe?

Our findings

The manager told us that during the weekend prior to the second day of inspection, two people had gone missing from the service without staff being aware of this for over two hours. Staff were alerted to the fact by an off duty member of staff who had found one of the people walking in Scarborough town. Staff had then realised that another person was also missing and they were found after they had taken a train to another town. Staff had assessed that neither of these people had the capacity to make the decision to leave the premises safely without support. Applications had been made to the relevant authority to assess these people for consideration of a deprivation of liberty safeguard (DoLS) to protect them. However, these were not yet in place.

Staff had not followed the provider's policy on missing persons. The manager told us that staff had been trained to use the Herbert protocol. This is a scheme where the service compiles useful information to be used in the event of a vulnerable person going missing which can be handed to the police. Relatives of the missing people were informed by staff on the day this happened and GPs were informed on the Monday morning following the incident. However, the staff on duty did not contact the police until prompted by the manager which was two hours after the people had gone missing. The information available to hand to the police was insufficient as staff had very little information regarding one person who had very recently been admitted as an emergency admission. Relatives of the missing people were informed on the day this happened. This amounted to an unsafe admission as the provider had not made sure they could meet this person's needs.

Both missing persons were found the same day and neither had suffered harm. However, there had been a significant risk of harm due to staff not following the home's own procedures. The manager had since offered staff support and retraining in the missing person's procedure and ensured increased staff supervision where required. They revisited the provider's admission policy and procedure with staff in a meeting held to discuss what had happened. They told us that only staff who were trained in assessment and with the authority to do so would authorise future admissions. The provider had fitted a new key pad door entry system which reduced the risk of people leaving the premises at times when staff were attending to the needs of others.

We found that people had not been protected from harm which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safe care and treatment)

Risk assessments were in place for each person who lived at the home. These covered such areas as falls, mental health and nutrition. Risk assessments were not sufficiently detailed in some cases to ensure people could be cared for safely. For example, we saw that a person had an epileptic condition which was not thoroughly risk assessed. Although staff could explain what they needed to do and had called 999 for an ambulance when this person had suffered a seizure, which was the correct action, all required actions were not written into the risk plan. Staff did not have clear written instruction on how to protect this person should they suffer a seizure.

A person was assessed as needing bed safety rails to protect them from falling out of bed. However, there was no bed rails risk plan in place. One care plan stated that a person did not always know when they were in pain and there was the risk of unrecognised injury. However, there was no injury or pain risk plan in place. Staff had written about a person in daily notes explaining how this person had become distressed and was "screaming and crying through personal care." Later the staff had noted, "[The person] was screaming and tried to punch staff and bit a staff member's arm." There was no risk plan in place for how to manage this person's care delivery to protect both the person and the staff who were giving the care. Moving and handling risk assessments were sometimes lacking in detail so that it was not clear how staff should move people safely.

This meant that there was a risk that people would not be cared for safely and was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people using the service had not been adequately protected and kept safe from abuse and avoidable harm.

At our last inspection we found that the service had not protected people with regard to infection control. At this inspection we found this area of care had improved. On the first day of our inspection we found that the provider was in the process of removing and replacing flooring to some of the downstairs areas. The flooring had already been replaced in the laundry room. Damaged furniture had been replaced. The flooring in the downstairs shower room which had been damaged and ill-fitting had been replaced, which reduced the risk of spreading infection. This meant that the risk of infection was reduced.

Staff told us that they used aprons and gloves when providing personal care and that they always removed these between attending to people. They also told us that they washed their hands between providing personal care to people to minimise the risk of the spread of infection. Sanitising gel was available at the entrance to the home, though on our visit we noted that the dispensing container was not clean, which the manager acted on promptly. Staff told us they had received training in infection control and training records which confirmed this. We observed improved practice in this area.

This meant that the home was no longer in breach of regulation with regard to infection control.

We did find some areas in the home which still needed attention. For example, pipework had yet to be covered in the laundry room and we were able to see areas where dirt could become trapped. The manager contacted us following the inspection to inform us this had been completed. An upstairs bathroom had ill-fitting tiles behind the toilet cistern and an area behind the toilet in the downstairs shower room was not covered over. The manager told us afterwards that this work had been completed. The laundry room did not have a hand wash basin for staff to use and staff had to wash their hands in a nearby facility. The manager told us after the inspection that this had been fitted.

We found that risk plans were in place for some people. For example, a person who was at risk of malnutrition had a plan to minimise the risk through ensuring regular meals and cutting their food into small pieces. This meant it was easy for the person to eat. Staff provided fortified foods and regular monitoring of weight. Another person was restricted as to the amount of fluid they could safely ingest each day and a risk assessment was in place for this. Another risk assessment had shown that a person required a bed sensor to alert staff to when they were moving about. This sensor had been fitted so that the person could be protected from harm.

We were unable to gather the views of people who lived at the service. However, we carried out observations of care during both days of inspection and gained the impression that people were settled and content at the home and did not appear to feel unsafe. One visitor told us that a person was at risk of falls and knew

the care plan stated they should be well supervised when moving around the home. They told us staff were good at noticing when the person was moving about and were supportive of them when they did. We spoke with a member of the community mental health team who told us that they felt the service worked well with people to reduce risk and that they were particularly good with managing people's behaviour which may challenge. They told us, "Staff are really calm and know how to work with people to deescalate situations quickly."

Medicines were stored and administered from locked trolleys on the ground floor of the home. The trolleys were not secured to the wall which meant there was a danger that they could be removed from their place of safety. This did not comply with the National Institute for Health and Clinical Excellence (NICE) guidelines about the safe managements of medicines. After the inspection the manager told us the trolleys had been secured and they would contact the local community pharmacist for further advice on safe handling of medicines.

The service operated a monitored dosing system (MDS). Each person had a medication administration record (MAR) which showed each medicine to be administered as well as the dose and time of day. All records had a photograph of the person to ensure they were easy to identify which reduced the risk of administering medicines to the wrong person. Stock balances were recorded on MARs and there were no gaps or errors.

Some medicines needed to be stored and managed in a particular way. These were called controlled drugs (CDs). The storage of CDs was safe and all medicines were accounted for and recorded correctly.

The staff administered PRN (as needed) medicines correctly. They provided homely remedies such as simple linctus and non-prescription pain relief. This meant that people had the option to use remedies they may choose which were not prescribed. The manager was planning to review the medicines policy to reflect the use of homely remedies and to incorporate the NICE guidelines on the administration of PRN medicines.

Accidents and incidents were recorded, though injuries were not always associated with body maps to show where the injury was located. The manager told us they regularly monitored these records and looked for trends so that they could form a plan to prevent further risk of incidents occurring. However we did not see any written evidence for this.

We examined staff rotas and spoke with the manager about how they decided on staffing ratios. They told us that the home was caring for 22 people with one person visiting the home for regular respite care at the weekends. At the time of the inspection visit, three care staff were on duty each morning with the assistant manager who also gave hands on care. There were two care staff on duty in the afternoons with the assistant manager after three pm. These figures excluded the manager who was on duty during the day and who at the time also provided hands on care. Two members of care staff, one of whom was a senior care worker and in charge of the shift, were on duty each night. Staffing levels at the weekend were the same as the week days but without a member of cleaning staff. The manager told us they had decided on these numbers after assessing the dependency levels of the people who lived at the home, though they did not use a recognised dependency tool. Our observations during the inspection, staff and visitors comments confirmed that there were sufficient staff to care for people safely.

After the inspection, the manager told us they had removed themselves from the care rota and had placed an extra member of care staff on duty to cover this. The provider had recently employed an assistant manager to share the managerial workload. They had also removed the assistant manager from working

shifts and had placed an additional member of staff on the rota to cover. The manager told us they considered the skill mix of staff when they organised the rotas, and staff told us they were placed on rota with people they could rely on and worked well with. This meant that there was an amended staffing complement of four care staff each morning and three each afternoon, with the assistant manager and manager in addition to this. The manager told us that extra kitchen staffing was now in place to prepare food at teatime which meant that care staff were not required to carry out this food preparation. Also there were cleaning staff on duty seven days a week. This was in response to the increasing needs of the people who lived at the home, and in particular for one person who now required closer supervision.

Staff told us that they had received training in safeguarding of adults and we saw written evidence of this. We saw there were safeguarding policies and procedures in place. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue.

We saw that staff had been recruited safely. We looked at the recruitment records for three care workers and could see that all the necessary checks had been carried out before they were employed including a check by the Disclosure and Barring Service (DBS). DBS checks support the service to make safer recruitment decisions. The service had also sought and received two references for staff. The previous registered manager and current manager had taken steps to check the background of care workers in order to protect people who used the service. Any gaps in employment were queried at interview if there was no explanation in the application form. The manager told us they had carried out disciplinary actions regarding staff who had not carried out their role in a safe manner and had taken appropriate action to protect people. This meant that the manager had taken steps to protect people from staff who were unsuitable to work with the people who lived at the home.

Requires Improvement

Is the service effective?

Our findings

Staff told us that they could regularly speak with the manager and raise any areas of concern. However, the manager told us that they had not yet had training in how to provide supervision and had not begun regular staff supervision and appraisal. They told us this was both due to their unfamiliarity with the process and other work they had been engaged in order to improve the safety of the service. Some supervision records from when the previous registered manager was in post were available; however, there was a lack of clarity about how accurate these records were as some staff did not recognise their individual supervision records when shown to them. Records showed that staff had received supervision within the last six months. However, staff who had been recruited since this time had received no supervision. Staff told us that they had received supervision when the previous registered manager was in post but that this had sometimes been informal and not recorded.

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

Staff confirmed that they had received an induction to the service before they began their mandatory training. Staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met. For example, one member of staff accurately told us about the care a person required including how they should be supported to move, their needs around nutrition and fluids, their medicines, pressure management and how the risks around their care should be managed.

We were not able to gather people's views about the effectiveness of their care. However, we spoke with two visitors. One visitor told us that the service supported a person well with their health care. "They have been really marvellous in getting the GP and other health care staff involved as soon as it is needed." They went on to tell us that the staff had accessed the correct pressure relieving equipment needed, and had followed advice of health care professionals in making sure the person had received effective pressure care. They were also complimentary about how the staff had worked to offer the appropriate food for the person. "They have been fantastic about [my relative's] diet. They built [the person] up from the last place [they] were living. It is astonishing that someone so poorly could have been brought back to life in the way they were."

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone and only did so when they felt confident within the role. This ensured they had the opportunity to understand people's individual needs and how risks were managed.

Staff received a range of training relevant to their role and records confirmed this was up to date. The manager told us about the training they considered mandatory, this included medicine handling training for all staff who had responsibilities in this area. Staff told us about other training such as dementia care and behaviour that may challenge. Two members of staff had epilepsy training and training in conditions associated with learning disability. Training was delivered mainly online. The manager told us that they felt this was not always the most appropriate way for training to be delivered and that they were sourcing practical face to face training for areas of care such as moving and handling.

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 process 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.

People's plans of care showed that the principles of the MCA Code of Practice had been used when assessing people's ability to make decisions. However, an assessment of people's capacity to make decisions was not carried out separately from the area of the care plan covering mental health and cognition. This meant that people's mental capacity was not always clearly assessed when this would be expected to ensure that people's needs were met. The manager told us that they were planning to improve this area of care planning to involve a separate mental capacity assessment where this was relevant to support staff to give people the right care.

The provider had a policy and procedure on the MCA and DoLS to protect people. Staff had received training in the MCA. They were able to tell us about the five main principles, for example that they should approach people with an assumption of capacity, and they should support people to make their own decisions. There were a number of people living at the home who had been referred for DoLS assessment. Most people who lived at the home had been granted the first urgent DoLS permission, however for a number of people the full assessment by an external professional had not yet been carried out. Although the DoLS had lapsed in some cases, the manager told us these people were protected as though the DoLS was in place.

We observed that staff routinely asked for people's consent before giving assistance and that they usually waited for a response. Care plans contained instructions on how to look for consent when people were not able to give this verbally, for example, through observing body language or facial expressions. People's preferences about their care were recorded for staff to follow.

Decisions which needed to be made in a person's best interests were recorded and evidence was provided that this was carried out with a multidisciplinary team approach as the MCA advises. An example of this was a decision about a person remaining at the home. The outcome of one Best Interest decision was written into notes about the person but the detail of how the decision was reached was insufficient for staff to understand. Although the manager understood how and why the decision had been made, staff who read the care plan did not have had all the information they needed to understand this information.

The home had links with specialists, for example the community mental health team and the speech and language therapy team (SALT). We noted one person had lost 11lb during the past five months with no analysis of why this may have happened and no referral to a specialist to follow this up. However, the weight loss had not resulted in the person becoming significantly underweight. We raised this with the manager and they told us they would refer the person to the SALT team which they afterwards confirmed to us. However, for other people we noted that specialists had been consulted where appropriate and their advice was written into care plans. This advice helped staff to offer appropriate and individualised care.

Care plans contained details of how to meet people's clinical care needs. Examples included pressure care, nutrition and fluids, and how to support people to move safely. The staff used the malnutrition universal

screening tool (MUST) which is a recognised risk assessment tool to determine whether people are at risk of malnutrition. The service had chair scales which could be used for people who were not in a position to bear their own weight, so that weight could be monitored.

The manager told us that individual food, fluid and positional change and turning monitoring charts were in place to protect people where necessary. These were accurately completed with no gaps and reflected the guidance set down in the care plan. The manager told us that they regularly monitored these charts.

People were shown example meals from which they could choose. We saw the daily menu was written on a board in a hallway. This was only useful to a small number of people living at the home who had the capacity to understand what was written. However, we noted that visitors and staff read the menu and then chatted with people about what was for lunch. The home had achieved a level 5 food hygiene rating which meant that the level of food hygiene had been assessed as very good.

Refreshments were available between meals and people were offered hot or cold drinks and snacks such as cake and biscuits. A visitor told us the home was very adaptable to their relative's changing needs and that the manager had gone out of their way to bring foods into the home that their relatives could eat and liked. A health care professional told us that when they visited the home they observed the food was of a good quality and that people enjoyed it.

We observed part of a lunch time meal during the first day of inspection where a hot meal was served and appeared of a good quality and quantity. Two care workers were supporting people at this time. This meant that staff was nearby people at all times to assist them. The food was well presented and people were given choices of drinks to have with their meal. Care workers were attentive to people's needs, and sat with them at eye level when they were supporting them with eating. This meant that staff responded to people's needs whilst eating and drinking.

Care plans contained information about people's likes and dislikes around meals. Those visitors we spoke with told us that people's preferences around food were respected. Specific diets to take account of medical conditions such as diabetes were recorded, and any adapted presentation such as pureed diet or food which needed to be cut up. Plates and cups to assist people to eat and drink independently were provided. This meant that people's needs in relation to food and drink were assessed and provided for.

Requires Improvement

Is the service caring?

Our findings

Two people had left the home premises without staff noticing this had taken place. They had neglected their duty of care to the people involved and those people had been placed in a distressing situation. Also, the provider had permitted the admission of a person whose holistic needs were not being met. This meant that the person was not being treated in a caring manner.

However, a visitor told us that the staff had been very caring with their relative. "They have been smiling and laughing with staff. The staff have all been very kind." One visitor spoke about how well the staff were caring for a relative who was reaching the final days of their life. "It is an enormous credit to this home, which is not after all, a nursing home, that they have cared for [my relative] so well right to the end. [My relative] is able to die here peacefully where they are comfortable". They went on to say, "The staff have been so supportive of me too. They have all been extremely pleasant and nothing has been too much trouble to make me feel welcome to stay with [my relative]. When I am not here they have updated me regularly on the phone so I know everything that has happened."

The manager told us that visitors were welcome at any time and visitors confirmed that staff were welcoming and that they were often offered refreshments when they called.

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. We saw that staff encouraged people to express their views and listened to their responses. Those people who were in discomfort or distressed were attended to with kindness. Staff reassured people where this was appropriate and showed that they were aware of people's likes and dislikes, those people who were important to them and details of their personal history. For example one member of staff told us about the previous family life of a person they cared for and how this impacted on their current care. Most staff gave the impression that they had plenty of time though some were at times moving about quickly and occasionally asked a question without waiting for the response.

None of the people who lived at the home had an advocate, though the manager told us that the advocacy service would be contacted should anyone require this. Everyone who lived at the home had a relative or friend who was designated to act on their behalf. The manager understood that an Independent Mental Capacity Advocate (IMCA) or an Independent Mental Health Advocate (IMHA) may be required when the person was assessed to need this. (IMCAs and IMHAs are a legal safeguard for people who lack the capacity or who require support due to their mental health, to make important decisions).

We observed that staff approached people with concern for their dignity. Staff told us that they respected people's right to privacy and dignity and spoke to us about using a kind tone of voice, listening to people and being sure to support people discreetly and in a way which made them feel comfortable.

The manager had organised eyesight and hearing tests and also dental check-ups for people who needed them so that they were in the best position to communicate their wishes and feelings.

Staff told us they had received training in equality and diversity within their induction to the service, and that they treated all people without discrimination. Since the last inspection the service had responded appropriately to an incident where this approach had not been followed. This had protected people's dignity and promoted their respectful treatment.

Staff told us about the way people were cared for in their final days. They emphasised the need for close liaison with palliative care professionals, attentive monitoring to ensure people did not suffer pain and how important it was to ensure people had company at their beside. They also spoke about the importance of supporting relatives, the people who lived at the home and each other at that difficult time. Care plans included details of who should be involved when a person reached the end of their life.

Care records contained details about palliative care professionals. Records showed that such professionals had been consulted and their advice had been taken.

Requires Improvement

Is the service responsive?

Our findings

The manager had admitted a person into their care who had specialist needs in relation to their physical and cognitive wellbeing. Their needs, due to this and to their age, differed significantly from all other people who lived at the service. Although two members of staff had training in some areas of care which the person required, the whole staff team did not have the specialist knowledge to meet this person's needs. The assessment carried out by the manager, and the care and risk planning, were insufficiently detailed to ensure that staff had the information they required to offer responsive and personalised care. There was insufficient information about the person's circle of importance regarding care needs, for example, people, interests, hobbies and plans for the person to develop and maximise their potential. The care planning had not focused on the person's important relationships with family, friends and peers and how these would be maintained and developed while they were living at the home. The person had recently attended five days of day care a week which had ceased when they began to live at the home. Although the manager told us they were thinking of ways to access alternative day care for this person so that they could remain in touch with people they were familiar with this had not yet been arranged. The provider had not approached this person's care needs in a responsive or holistic manner.

This meant that the home was not responsive to all people's needs and was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Person- centred care).

We raised the admission of this person with the local authority commissioners, who arranged for the person's needs to be reassessed and plans drawn up for their on-going care and support.

The manager told us that the provider's statement of purpose did not include how they would meet the needs of this person or of any other person they decided to admit with comparable needs.

This was a breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2010 (Statement of purpose). This will be followed up separately with the registered provider.

Care plans in general were not signed by people or their representatives although visitors told us that the manager had consulted with them while completing their care plans. Plans did not contain sufficient information about how people or their representatives were consulted and how their views and preferences had informed each area of care planning. This would have shown that people's preferences and wishes had been acted upon.

We were not able to gather the views of people who lived at the service on how responsive the staff were to their needs. However, visitors told us the staff were responsive to people's needs and that they understood about people's lives and what was important to them. One visitor told us, "The staff listen to what I want and what [my relative] wants and they do their best to make sure that [they] receive the care I think is right."

Reviews focused on wellbeing and any improvements which could be made to people's care. As care plans were not always up to date, reviews were work in progress and were not always recorded with detail. The

manager told us that relevant specialists were consulted for advice at these reviews. Health and social care professionals told us that they had been consulted and that the manager was working hard to update plans and ensure people received the care which reflected their needs and wishes.

Despite the shortfalls in personalised care planning, some people's care plans did contain areas of interest, likes, dislikes and preferences. Staff had worked with some people and their families to write life histories. Some plans contained information such as previous occupations, hobbies, family and friendships, spiritual needs, preferred clothing and ways to spend time. Where people did not have the mental capacity to give a view, the manager told us that efforts had been made to consult with others who were important to them, advocates or Independent Mental Capacity Advocates (IMCAs). However, these consultations were not always recorded.

Staff engaged people in one to one or group activities according to their preferences. The manager had rearranged the communal space to provide a room for activities where we saw such games as skittles, balls, bean bags and other hand and eye coordination games. We observed a game of catch during the inspection visit and people appeared to enjoy this. The manager told us that one person enjoyed getting involved with household chores and they were supported to do this. An external entertainer visited the home to sing to people from time to time. People's preferences around daily activities had been recorded, however the manager told us that people rarely went out and visitors confirmed this. The home had no garden or outdoor space; however, there were nearby open spaces, shops and cafes that staff could easily access. Staff told us that they did go out with people, but not very often. The manager told us they were planning to arrange rotas so that staff could take a small group of people out for a walk, or to a local café.

There was some evidence that the provider had considered the environment and there were a number of signs on doors such as bathrooms and personal bedrooms to support people to identify them. One lounge had a tank of fish for people to watch. There were games and colourful items in the activities room to engage people's attention. There was a selection of soft toys and dolls for people to use and a knitted hand muff, which was studded with a variety of different textured buttons and materials for people to explore. People were freely using and engaging with these objects and they were used as points of discussion by staff.

However, pictures decorating the walls were not appropriate for people who were living with dementia. These did not provide opportunities for memory work and some were uninteresting and of poor quality.

During a morning observation staff encouraged people to chat with them and each other, and they listened to what people had to say, responding to their needs. They brought people refreshments of their choice and supported people to sit at a distance from the television to allow them to clearly hear and see the programme they were watching.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had written communications to help them to offer care which was responsive to people's needs.

Staff could tell us about people's care needs and how these had changed. They explained how referrals to health care professionals had been made to ensure care remained appropriate for each person.

Visitors told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously. We saw the provider had a complaints procedure and staff told us this was followed. One visitor told us, "If I had anything to complain about then I would talk about any problem with the manager or

with the staff on duty." The manager had recorded no formal complaints but told us that they resolved all complaints informally with people coming to speak directly with them. This meant that people's concerns may not be fully responded to and that the manager would not have an oversight of the concerns raised when monitoring the service. The manager told us that they were planning to record concerns in more detail with the outcome so that they were able to monitor people's satisfaction with how these were handled. After the inspection they reported to us that they had begun to do this.

Inadequate

Is the service well-led?

Our findings

The registered provider had not informed CQC about the safeguarding incidents, when people went missing from the home. They had, however, informed the local authority. The manager had recently taken up their role and told us that they did not yet understand the responsibility of the registered provider to inform CQC of safeguarding or other incidents. There were a number of safeguarding incidents which were being investigated by the local authority that CQC had not been informed about directly by the registered provider.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2010 (Notification of other incidents). This will be followed up separately with the registered provider.

The manager told us they carried out a small number of checks and audits, but these were in the early stages of development. These included checking risk areas such as the environment, infection control, medicines, accidents, kitchen safety and training. Not all of the audits were written down and there was limited evidence of action plans arising from the auditing. Records such as care plans and risk assessments were not all up to date and there was insufficient evidence that these had been regularly reviewed. Policies and procedures were out of date and required updating. This meant that the registered provider did not have the information they needed to monitor and plan improvement to the safety and quality of care in the service. It also meant that the staff did not have access to up to date information regarding current best practice and requirements which placed people in their care at risk.

The registered provider was not visible in the service and we saw no examples of their oversight and leadership. There was no evidence of their governance or input to safe and efficient operation of the service, especially during the period when there was no registered manager in post.

This lack of leadership, management and governance by the registered provider meant that the safe delivery of care was not assured and we found multiple examples where people living at the service had been placed at significant risk of harm. This was a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.(Good governance)

The home did not have a registered manager in place. The registered manager had left their post in April 2016 and was now deregistered. The current manager had worked at the home as a senior care worker and taken up the post of manager in June 2016. He had applied to us to become registered and his application was under consideration. He was at the early stages of implementing changes and was supported by a recently appointed assistant manager.

The manager told us that the registered provider was supportive and encouraged them to discuss issues in a positive way. However, we did not see any formal induction records for the manager or written evidence of one to one support and supervision from the provider. The provider was not supporting the manager in a practical way with staff supervisions or working with them around staff discipline and national guidance and legal requirements. This meant that the manager was not receiving the full support they required to manage

the service effectively and safely. In turn this placed people who were using the service at risk.

We spoke with representatives from the local authority which commissioned care at the service. They had dealt with concerns through the safeguarding process around the people who had gone missing from the home, and other concerns around safe, timely and appropriate care and treatment of people. They had also expressed concerns about the quality of management and the support for the manager in their role from the registered provider. They had placed the service into 'low level concerns' which meant they were monitoring the safety and quality of care at the service and they were considering whether to suspend admissions to the home. We found that admissions had been suspended after the inspection.

After the inspection, the manager told us they had removed themselves and the assistant manager from the care rota so that they could focus on their managerial roles with the agreement of the registered provider. They told us that following this change, both they and the assistant manager were in a better position to carry out the managerial work necessary to improve the safety of the service.

Visitors we spoke with told us that the manager often stopped to have a chat and that they were approachable and acted quickly when they mentioned areas of concern. We observed that the manager was available to people who lived at the service, staff and visitors during our inspection and that they had a good rapport with the people they spoke with.

The manager had held two recent staff meetings to communicate information and to encourage staff to give their views. Staff told us that the manager was open and positive with them, and that they felt supported in their role. They had daily access to the manager who encouraged them to ask questions and to call him if they needed advice and guidance outside of usual hours.

People had completed surveys to gather their views about their care but these were out of date by two years. The manager was planning to re-introduce surveys and other ways of gathering people's views about their care such as arranging to spend time with them alongside their visitors.

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 Care plans were not sufficiently personalised to ensure people had all of their care needs met. Regulation 9 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that risks were safely managed. People had not been protected with regard to the missing person's procedure of the home. Regulation 12(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not sufficiently detailed to support staff to give safe, quality care. Notifications had not been sent to CQC by the home as required. The statement of purpose was not up to date. The provider's monitoring system was insufficient to ensure the manager had the information needed to improve the service. The provider had failed to actively monitor and govern the service in the absence of a registered manager. Regulation 17(2)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff did not receive formal supervision to support them to develop in their role. Regulation 18(2)