Horizon Care (Derby) Limited

Ivy House

Inspection report

138 Whitaker Road
Derby
Derbyshire
DE23 6AP

Tel: 01332294502

Date of inspection visit:
06 November 2018
07 November 2018

Date of publication:
29 January 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 6 and 7 November 2018 and was unannounced.

Ivy House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ivy House accommodates 20 people in one adapted building. The service specialises in caring for older people including those with living with dementia. At the time of our inspection 17 people were in residence.

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.

This was the first inspection of the service since they were registered in December 2017. At this inspection we found evidence to support the rating of 'requires improvement'.

The provider did not have systems and processes to assure themselves about the quality of service provided. There was a lack of oversight on the service and monitoring was ineffective.

People were not safe. Risks associated with the premises had not been effectively managed. People were not protected from the risk of burns or scalding from excessively hot surfaces. We found fixtures, fittings and furniture were damaged and not safe. Infection control procedures and practices were not always followed. Maintenance was not provided in a timely manner to ensure the premises were safe and fit for their intended purpose.

We found medicines were not stored safely. The registered manager removed and returned all the medicines that were no longer used to the pharmacy. Further action was needed to ensure medicines were stored securely in people's rooms and people were supported with their medicines as prescribed.

Staff recruitment process was not followed to protect people from unsuitable staff.

There were enough staff to meet people's needs. A system was in place to ensure staff were trained and supported in their role. Further action was needed to ensure staff training was kept up to date and staff practices were observed and monitored.

Risks associated with people's needs had been assessed; safety measures were put in place and they were monitored and reviewed regularly.

People's dietary needs were met. Drinks and snacks were available. People had access to health care services.

People were involved in decisions made about all aspects of their care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were cared for by kind and caring staff. Staff knew people well; understood their wishes and daily needs. People had the opportunity make decisions about their end of life care.

People did not always receive care that was person centred and responsive. People's dignity and privacy was not always respected. Care plans lacked information and clear guidance for staff to follow to provide person centred care such as guidance provided by health care professionals, food preferences and hobbies.

The provider employed an activity co-ordinator but people's experiences about the activities, social stimulation and engagement varied. People were not always protected from the risk of loneliness.

Information was made available in accessible formats to help people understand the care and support agreed. The provider was developing picture menus to help people living with dementia choose what they want to eat.

People and their relative knew how to make a complaint and felt confident that action would be taken. However, there were limited opportunities for people to express their views about the service and influence how the service was run.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People were at risk from harm as the provider had not ensured the premises and equipment were safe and well maintained. Infection control procedures were not consistently followed. Medicines were not stored securely. Staff recruitment procedures were not always followed.

Risks to people's needs were assessed and managed. People were supported with their medicines.

Staff understood their responsibilities to keep people safe from harm. Staff were trained in safeguarding and knew how to report concerns. There were enough staff to provide care and support to people when they needed it.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by trained staff. Improvements were needed to ensure staff training was kept up to date and staff practices were monitored.

People's needs were assessed. Staff sought people's consent and understood people's rights. Capacity assessments had been put into place to identify the support people needed to make decisions.

People's dietary needs were met despite the lack of detail in the care plans. People were supported to access health care support when they needed to.

Is the service caring?

Requires Improvement

The service was not always caring.

People were cared for by caring and kind staff. People had been involved in planning their care. People were treated respect. However, people's privacy and dignity was not always maintained by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed although decisions made were not always documented. Care plans were not personalised to include people's preferences and cultural needs. Despite this people felt their care needs were met by staff who knew people well.

Staff promoted equality and diversity, and respected people's values and their backgrounds. People's experiences about social stimulation and engagement varied and did not always protect people from the risk of loneliness.

Information was available in accessible formats. People knew how to complain and were confident that any concern would be dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well.

There was a lack of oversight and ineffective governance systems, processes and practices. Policies and procedures were not kept up to date and followed. Lessons were not always learned from events and improvements were not made in a timely manner. There were limited opportunities for people using the service and staff to make comments and to influence changes.

The service had a registered manager. People, visitors and staff felt the registered manager was approachable.

Ivy 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 checked 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 6 November 2018 and was unannounced. The inspection team consisted of two inspectors and an expert-by experience. The expert-by-experience had personal experience of caring for someone who uses this type of care service. One inspector returned on 7 November 2018, announced to complete the inspection.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

Before the inspection, the provider had returned the completed Provider Information Return (PIR). This is the information we require providers to send us as least once annually to give some key information about the service, what the service does well and the improvements they plan to make. There was a technical problem which meant the PIR was not received. We gave the provider the opportunity to provide information, which was used to inform the judgements in this report.

We reviewed information we held about the service. This included feedback received about the service and notifications the provider had sent us. Notifications provides information about important events which the provider is required to send us by law. We contacted Derby City Council, who commission services from the provider; and Derby City Healthwatch, an independent consumer champion for people who use health and social care services. They had no concerns about the care provided and noted the ongoing renovation and decoration.

During the inspection, we spoke with four people who used the service, eight relatives and three friends. We made direct observations at meal times and 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 spoke with the registered manager, three senior care workers, two care staff, the activity coordinator and the housekeeping staff member. We reviewed a range of records. This included seven people's care records and five people's medicines and medicine administration records. We looked at four staff recruitment files, training records and records relating to the management of the service such as policies and procedures, accident and incident reports and quality audits.

Following the inspection visit the registered manager sent us regular updates regarding the monitoring and progress of works being carried out. This specifically related to surface temperatures of the radiators and the protective radiators covers being fitted. We took this into account when we made judgements about Ivy House.

Requires Improvement

Is the service safe?

Our findings

People's safety was put at risk because the home environment was not safe. On the first day of our inspection visit we found all the radiators in communal areas and in people's rooms had extremely hot surface temperatures. None of the radiators had protective covers on. This is important to protect people from the risk of burns or scalding through prolonged contact with hot surfaces. Some radiators were rusty and damaged which could cause injuries such as skin tear. We raised this as an immediate concern with the registered manager who told us they would take action.

On the second day of our inspection some radiators had cooler surface temperatures. The registered manager assured us they would carry out daily checks of all the radiators to minimise risks to people until a permanent safety measure was put in place.

We found fittings and fixtures around the home were not safe. Risks were found in most bedrooms such as window blinds did not close or were broken, loose electrical cables hanging from the ceiling and walls, an uncovered fuse box and unsecured electrical sockets being used for pressure relieving mattresses. There were ill-fitted and unsafe bathroom furniture and pipework. Fire extinguishers were found on the floor in a corridor close to the laundry room. The staff member could not explain why it was there and where it belonged. Our findings showed that people using the service could be at risk of injury and a further risk of unable to access the fire extinguisher in the event of a fire.

Furniture such as some wardrobes in people's rooms and the dining room wobbled and were not secured to the walls. Unsecured furniture could fall onto people. Bedside cabinet with missing drawers. There were three wheelchairs without footplates stored in close to the lounge. A box containing different sets of footplates was left on top of the wheelchairs. Although we did not see anyone using wheelchairs there was a risk that wheelchairs would be used without footplates.

The outdoor space was not safe or accessible for people to use. The garden to the rear and side had old and damaged furniture such as armchairs, pressure cushions and wheelchairs. There were paint tins and plastic crates stacked on the floor and filled rubbish bags. The two small ponds to the front of the home were not secure. Although the pond was shallow it was a potential risk to people if they were to fall into the pond as it was not covered.

We shared our findings with the registered manager and some action was taken immediately. This included securing the wardrobes in people's bedrooms and storing fire extinguishers securely in the designated areas within the home.

On the second day of the inspection the wheelchairs and box of footplates had been stored elsewhere. Maintenance staff were in the home attending to some of the issues that we had identified. However, further action was needed to make the environment safe for people.

We found infection control procedures were not followed. An armchair in one person's room had ripped

covers with the internal padding exposed. Damaged furniture could harbour bacteria and was a potential fire risk. The registered manager told us the arm chair would be replaced.

There were no paper towels in the communal toilets and bathrooms. Disposal gloves were available and used, however, there were no disposable aprons in the dispensers throughout the home. We raised our concerns with the registered manager, disposable aprons were put in the dispensers and paper towels were available in the communal toilet and shower room. However, some people's ensuites toilets still had no paper towels.

Staff were seen using disposable gloves when supporting people with personal hygiene needs or handling food. Staff told us they had received training in infection control and prevention but the training records showed some staff were overdue infection control training. Further action was needed to reduce the risk of spreading infection because staff wore jewellery with stones, which can harbour bacteria and could cause a skin injury to a person, for example, when staff provided personal care.

All the bedrooms had ensuite shower and toilet facilities, however, staff told us most people used the communal shower room because it was spacious. Further infection control risks to people were found when we looked in the communal shower room. People's used wet towels and dirty under garments were left on the chairs and the floor. Items such as continence pads and coat hangers were left lying around, which could cause a further risk of injury. There was a large soap dispenser left on the floor. Communal toiletries were being used such as shower gels, deodorant and scrunches. Other risk found included used disposal razors and nail brushes left lying around. We found more toiletries and packet of disposable razors in the cabinet under the wash hand basin. These items were removed immediately when we made the registered manager aware.

There were offensive odours in various parts of the home despite cleaning taking place regularly. That showed cleaning was not effective or monitored.

Records showed regular safety checks had been carried out on the premises and cleanliness. An action plan had been developed but most improvements were overdue. In addition, the issues we found had not been identified.

The fire and general home risk assessments had not been updated following the structural changes made to the premises. We made the registered manager aware of this.

We found people's medicines were not stored safely. People's prescribed topical creams tubs and ointments were found in communal shower room cabinet. Staff were unable to tell us who those items belonged to because some prescription labels were not legible.

We found medicines were not stored securely in people's rooms. For example, prescribed topical sprays were being used to prevent skin damage and infection and an opened packet of wound dressing were found in one person's room. One spray had been dated as 21/03/2018, when it was opened as it only has a shelf life of 28 days. That meant the person was administered medicines that were ineffective and not safe to use. The registered manager removed the sprays and new prescriptions were ordered.

We found more prescribed topical creams in people's bedrooms that were not stored securely. Medicines charts were not completed accurately to confirm when and where the topical creams had been applied. One person's prescribed topical creams were found in someone else's room. The registered manager returned these items to the correct person's room.

Medicines that were no longer used and needed to be returned to the pharmacy were found in plastic containers in the office and corridors on the first floor near to another office. Although people did not access that area, it showed medicines were not stored securely.

On the second day of our inspection the registered manager had taken steps to ensure the medicines no longer used had been returned to the pharmacy. Some people's bedrooms had a new lockable medicine cabinet. Further action was needed to ensure the medicine cabinets were fitted securely.

These were evidence of a breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's wellbeing, safety and health had been at risk.

Following the inspection visit the registered manager wrote to us to confirm that the radiators covers would be fitted to all radiators by 2 December 2018 and sent us regular progress updates. The water in the pond had been removed to minimise the potential risks to people.

A staff member said, "I started my induction training after my [pre-employment] checks were done." However, further improvements were needed to ensure staff recruitment processes were followed to protect people from unsuitable staff. Two staff files contained all the relevant checks such as employment history, references and a Disclosure and Barring Services (DBS). A DBS check helps the employer make safe recruitment decisions. However, the DBS were over three years old. Two other staff files had no record of DBS checks.

The registered manager told us that staff terms of employment had been transferred over to the provider from the previously registered provider. However, there was no evidence that risk assessments had been completed to ensure staff were suitable to work in care. The registered manager told us there was no guidance about the renewal of staff DBS.

This was a breach of Regulation 19, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff recruitment procedure had not been followed to protect people from unsuitable staff.

People told us they felt safe with the support provided by staff. We saw people were being supported by staff to move around safely when using walking aids. A relative said, "My [family member] wouldn't be here if I didn't think it was safe for [them]". Another relative said, "I feel [they] is safe here. It was welcoming friendly and homely."

Systems, processes and practices to safeguard people from situations in which they may experience abuse were in place. Information about how to report concerns and whistleblowing was displayed and accessible to all staff, people who used the service and their visitors.

Staff understood how to identify signs of abuse and preventable harm and knew how to report these; staff knowledge in safeguarding adults had been supported by training in this area. A staff member said, "We always do our best to keep people safe. If anything happened then I would report it to [registered manager] or tell social services if nothing happened."

Risks to people's physical and mental health had been assessed and measures were in place to keep them safe. These covered a variety of aspects including, falling, moving around and swallowing difficulties. For example, one person had a sensor mat placed near to their bed to alert staff when they were moving around and could support them.

Staff understood risks to people and how to support them and care plans gave instructions about how to keep people safe. For example, staff ensured a person always used their walking frame to move around and gave clear directions. Another care plan described the food texture required where the person had a swallowing difficulty. At lunch time this person was provided a meal that they could eat safely.

Risk assessments had been reviewed following a change in people's needs to make sure they were up to date and based on the person's current needs. Each person had a personal emergency evacuation plan (PEEP), which described the support they would need. Staff knew what action to take in the event of an emergency and where the PEEP folder was kept.

People told us they received their medicines on time. A relative told us, "[Staff] make sure my [family member] has [their] medicines on time and that's made a difference to [their] health." Staff were trained before they administered medicines and the medicine procedure and supporting guidance was accessible to them. Care plans had information about the support people needed and how they preferred to take their medicines. We saw a senior care worker administered medicines to people individually and signed the records to confirm this. They followed medicine protocols where people were prescribed medicines to be administered 'when required' such as pain relief. This helped to protect people from the risk of overdosing.

People told us staff were available when needed. A relative said, "Most [staff] have been here a long time". Another relative said, "Staffing is good, always the same reliable staff which is important because my [family member] has dementia."

Staff we spoke with felt there were enough staff to support people. Their comments included, "We don't really use agency staff. If someone is sick then we will cover or the [registered manager] works." We saw there was at least one member of staff in the lounge area and they responded to people's requests when needed. Staff rotas showed that staffing levels were maintained and arrangements were in place to manage staff sickness. This contributed to people's safety and assured them their needs would be met.

All staff understood their responsibilities to record any accidents and incidents that may occur. Records showed incidents and accidents had been documented and were analysed by the registered manager to identify any trends so that action could be taken. Any lessons learned from incidents and external inspections were shared with staff. This included issues that we found on the first day of our inspection visit.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us staff were trained and provided care that met their needs. We saw staff supported people to move around the home safely and knew how to help people.

A staff member said, "On my induction I did fire and health and safety training, and read people's care plans. I worked with another carer until I felt confident to support people." Records showed that not all staff had completed their induction training. Another staff member said, "Training is good. I have done all my training like safeguarding, health and safety, food safety, hygiene, moving and handling and challenging behaviour."

Training records showed most staff had completed training relevant to their role to deliver effective care in the form of practical and on-line courses. Where staff were overdue training on topics such as infection control, health and safety and pressure care management, training was booked but the dates were not known. Further action was needed to ensure all staff had completed the induction training, their competency had been assessed and ongoing monitoring to ensure staff put the learning into practice, such as following infection control procedures. The registered manager assured us action would be taken.

Staff were encouraged to complete a professional qualification in care and the care certificate, which covered the basic standards required for staff working in care.

Staff felt they could approach the registered manager if they felt unsure or were not confident to meet people's needs. Staff had regular supervision and an annual appraisal. This gave staff the opportunity to discuss working practices and identify any training or support needs. Staff meetings were held regularly. The meeting minutes showed that staff were made aware of developments in the home, such as the decoration and planned training.

People's needs had been assessed before they moved into the service, to ensure their needs could be met. Assessments covered people's physical, emotional, cultural needs and preferences. Information gathered from people, their relatives and relevant health and social care professionals such as dietitian, was used to develop the care plans. Staff we spoke with understood the needs of people they supported.

Relatives told us that staff sought medical advice when needed and kept them informed about any concerns about their family member's health. A relative said, "[Staff] do a really good job and they arrange for a doctor or ambulance for my relative and they keep me informed." Where possible relatives were involved in their family member's care for example, a relative was taking their family member to attend a dental appointment.

We saw some people did not have dentures. Unless provided by family, people did not have a toothbrush or toothpaste. That meant people were not supported with daily oral hygiene and dental care needs. Where people had dentures, there were no denture products found in their room. When we asked a staff member about dental care and they said, "[Person's name] has not been to the dentist – not required [no teeth]". There was an assumption that people did not require oral health checks.

Care plans referred to people's eating and drinking, eyesight and hearing but little or no reference made to oral hygiene needs; the support needed and products used. The lack of oral hygiene regime and access to routine dental checks does not promote healthier lives and health risks may not been identified and managed. The registered manager assured us the care plans would be updated and include the best practice guidance regarding oral hygiene.

People had access to health care professionals such as the GP, specialist nurses, optician and podiatrist. Any change in people's health was recognised quickly by staff and prompt and appropriate referrals were made to healthcare professionals. Staff told us they had a good relationship with health care professionals that visited the service.

People were supported to maintain a healthy balanced diet and those at risk of not eating and drinking enough received the support they required. Referrals to a dietitian and speech and language therapist had been made when required and advise was followed. Despite the lack of information in care plans about people's food preferences, staff were aware of what people liked to eat and drink. Instructions on how to prepare thickened drinks for people with swallowing difficulties were not included in the care plans but kept in the kitchen, which staff could refer to.

People told us the food was good. One person said, "The meals are alright, I enjoy egg and bacon for breakfast." Relatives comments included, "My relative gets plenty to eat" and "The meals are generally good, but sometimes my [family member] has sandwiches."

We saw drinks and snacks were offered to people throughout the day. Staff were aware of people's dietary needs and provided meals that were suitable. For example, one person required a soft fork mashable meal which was provided. All the meals were fresh frozen and heated up on the day. There was a choice of drinks served at lunchtime. Although alternatives were available, we saw one person was not offered an alternative meal only a choice of desert, which they ate. We saw one person kept pushing the food around on their plate. No support was provided by staff. We shared our observations with the registered manager.

On the second day the lunchtime meal was much improved. We saw staff were encouraging and supporting to eat and drink. Alternative meals and deserts were offered to people.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 the authorisations to deprive a person of their liberty had the appropriate authority and were met. We found appropriate DoLS authorisations had been requested and conditions on authorisations to deprive a person of their liberty were being met.

Records showed people had consented to their care. Assessments had been conducted to determine people's ability to make specific decisions. A relative told us they and a health care professional had been

involved to make best interest decisions for their family member.

Staff had received training in relation to MCA and DoLS and had access to a MCA policy. We saw staff involved people in making decisions about their care. A staff member said, "[Person's name] will choose what [they] want to wear; I would hold up no more than two outfits otherwise [they] gets confused."

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People could choose where they spent their time, such as in their own room or in communal areas and could move freely around the home.

The local authority and HealthWatch had told us about the ongoing renovation and decoration and continued during our inspection visit. Some bedrooms were personalised to reflect people's personal taste. Some areas of the home were dark and poorly lit. When we asked staff about this they promptly switched on the lights.

Technology and equipment such as a sensor mat were used to alert staff when people needed support and was used effectively to meet people's care and support needs. There was a chair lift, which people used to access the first floor.

The registered manager told us people had used the garden on warmer days where outdoor seating was available. We found further improvements were needed to create an environment internally and externally that was suitable for people living with dementia. For example, good lighting, suitable clocks and clear signage to enable people living with dementia to find their way around the home and to their bedrooms. The view from one person's bedroom window was an over-filled skip. The skip had been emptied by the second day of our inspection visit.

Requires Improvement

Is the service caring?

Our findings

We found instances that showed people's care was not individualised and their dignity and privacy was compromised. For example, a person could walk independently but unable to have a shower in the privacy of their room because a standing up aid was stored in shower.

We saw people's dignity had been compromised when using the toilet close to the lounge because the door opened outwards. When we brought this to the registered manager's attention and they told us they would inform the maintenance staff to make improvements so to maintain people's dignity.

People had an ensuite shower in their room but most people did not have their own toiletries. We found a selection of toiletries and topical prescribed creams in the communal shower room. Although staff member told us most people used the communal shower room which was bigger we were unable to confirm whether people had been given a choice about using their ensuite shower or the communal shower room. This showed staff did not promote people's dignity.

The provider met the requirements of the General Data Protection Regulation (GDPR) and people's personal records were stored securely. Although staff were aware of the confidentiality policy we found people's confidentiality was not always maintained. Someone else's medicines were found in one person's room. The registered manager took action immediately but ongoing monitoring was needed to maintain people's confidentiality.

We did observe staff knocked on doors before entering, and were aware of protecting people's dignity when personal care was required. At lunch time people were offered and provided with clothes protectors so that their clothing would be protected from spillages.

A relative told us that staff respected their family member's privacy and dignity and addressed them by their military title. They said, "[Person] is particular about who supports [them]. Staff knows [their] routines and pay particular attention to maintaining [their] appearance, which is important to them." Other comments included, "Staff have managed [their] care needs. They look after [them] very well, recognised and managed [their] needs. [They] is always shaven, clean and never wet." "[Staff] have [person's name] interest at heart. Two staff help [them] in the shower and respect [their] dignity." And "All the staff are taught to respect my relative."

A relative spoke positively about staff and how they encouraged and supported their family member to regain confidence and independence. They said, "[Person] has been dressing [themselves] now for two weeks which is good."

People and their relatives told us staff treated them with respect and were kind and caring. The comments received included, "The staff are friendly and the care is good." "The Eastern European staff are excellent." And "All the staff are very kind and know [person's name] well."

People looked comfortable seated in the lounge and in the privacy of their bedroom. We saw staff addressed people by their chosen name and knelt to speak with people when they were seated. Staff understood people's behaviours throughout the day, and knew how to support people if they needed to use the toilet or felt anxious. For example, after lunch a staff member walked with a person to and from the dining room until the person wanted to sit down.

One person was celebrating their birthday. We saw staff made the person feel special and complimented them on the new outfit worn. A birthday cake and buffet tea had been arranged for everyone including the person's family who were visiting.

Visitors to the home were greeted by staff in a friendly and warm manner. For example, when a person returned from a medical appointment with their relative they were offered a hot drink. The staff member enquired about the appointment as the person made themselves comfortable.

A relative said, "They persuade [person] to go to the dining room because otherwise [they would spend all day in [their] room. The staff, when [their spouse] was alive and living in the home, organised a candle-lit dinner in the dining room on [their] special day." Another relative told us staff knew their family member well and said, "I come in day and night, and ask how my [family member] is. I am always; firstly, greeted and secondly, told how [person] has been that day."

People were involved and supported to make decisions about their care. Some people had supportive relatives who told us they had been involved in the planning and reviewing of their family member's care. Any decisions made were documented. Advocacy information was available if people required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

People's views were about the support they received was sought individually. Relatives were confident to speak with the registered manager and staff team when needed. A suggestion box with comment cards were available in the reception area so that people, visitors and staff could give feedback anonymously, if they wanted to.

Requires Improvement

Is the service responsive?

Our findings

People received care and support that was mostly responsive. People and their relatives were involved in the development of the care plans.

Care plans had information about people's needs, support required and information about their early life, family and interests. Some care plans were detailed. One care plan stated, 'food needs to be cut into small pieces'. Another person's care plan stated 'feels a sense of needing to fetch the kids and run errands', which showed an insight into the person's behaviour and how staff should support the person. A relative told us staff understood their family member's needs well and provided assurance and support when they became anxious.

However, other care plans lacked information and guidance for staff to follow such as people's cultural diets and food preferences, daily routines and support needed to promote and maintain their independence. A staff member recognised behaviours such as grinding teeth and sounds made to indicate someone may becoming anxious but how staff responded varied. This showed inconsistent support provided.

A staff member described how they prepared drinks for a person with a swallowing difficulty, "It's a purple spoon used, you put not a half or quarter but in between [amount of thickener powder]." There was a list of names of people with their preferred drinks and instructions of one or two scoops of thickener required for people with swallowing difficulties. However, this information was not consistently found in care plans including the guidance provided by the dietitian. Monitoring records such as food and drink consumed and re-positioning a person nursed in bed was not always documented.

Further action was needed to ensure people experienced quality care in all aspects of their daily lives. Meal time experiences were not always enjoyable. There were no napkins, table cloths or condiments so that people could help themselves. Review of people's care needs did not always take account of daily support provided, any concerns about people's physical and mental wellbeing and feedback for the person and their relative, where appropriate.

The activity coordinator had responsibility to complete 'This is Me' document, in discussion with people and their family about their interests, hobbies and food preferences. We were given a folder which had eight partly completed documents, since May 2018. The information gathered was not meaningful or reflected people's preferences or interests.

We shared our findings with the registered manager. They told us they would support the activity coordinator to complete the 'This is Me' document and use the information to develop the care plan to enable staff to provide person centred care.

The service ensured people would not be discriminated under the Equality Act, based on their gender, race, religion or sexuality. There was equality and diversity policy in place and staff received training on this. Information about people's diverse needs had been identified during the initial assessment or gathered

from relatives but not always included in the care plan. For example, staff told us and we observed a person had enjoyed a home cooked traditional meal which was brought in by their relative. The registered manager told us they would amend the person's care plan.

Staff knew people's communication styles and ensured information was available in formats that people could understand. Some people had a summary easy read pictorial care plans. However, at lunch time we did not see staff use picture menus or showed the meal options to enable people to make choices about what they wanted to eat. The registered manager told us picture menus would be developed. This showed the provider was taking action to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Feedback we received from HealthWatch was positive about the social events and activities provided for people. The full-time activity co-ordinator had set up arts and crafting activity in the dining room. One person sat at a dining table to do some colouring in, whilst the activity coordinator sat at another dining table making poppies on their own. Most people were sat in the lounge. We saw a staff member playing 'catch the balloon' with some people in the lounge before lunch.

When we asked people and relatives about social events and activities, they said, "Not many [activities] take place. There are crafts today, this was the first time I had seen any activity take place." "There was a party a while ago. There are no activities carried out on a regular basis." And, "I am concerned about [their] loneliness i.e. [they] like to remain in [their] room. The staff are aware of this and persuade and encourage [them] to eat in the dining room or sit in the lounge for a short while."

People's religious and spiritual needs had been identified but it was unclear how they were met. A relative did tell us that a Parish Priest had visited the service but left on one occasion because no one answered the door.

Pet therapy is a positive way to encourage psychological or physical stimulation for people. The provider's cat was known to people and their visitors. One person told us they liked having the cat in their room so made sure the bedroom door was left open in the afternoon. Appropriate risk assessment was in place and staff ensured the kitchen door was always closed.

The provider had a system and a policy in place about how to support people at the end of their lives. People had the opportunity to express how they wished to be cared for at the end of life. Records showed people's views and wishes had been sought where possible to remain at the home and not be admitted to hospital. This assured people that staff would provide the support they needed and respect their wishes. No one was receiving end of life care.

There was a clear complaints policy and procedure in place. People and their relatives said they knew who to speak to at the service if they had any complaints. Most relatives were positive about how complaints and concern were managed and said, "[Registered manager] has dealt with any problems quickly" and "No [complaints] but I would talk with the [registered] manager and sort things out. It helps that there is a low turnaround of staff."

The complaints log showed the service had not received any complaints. The registered manager responded to concerns we received from relatives, which showed that complaints were managed and action taken as required.

Inadequate

Is the service well-led?

Our findings

The provider's governance systems and processes were fragmented and did not drive improvements. Records showed some audits had taken place. The audits had identified issues such as inconsistent information in the care plans and overdue staff training. The health, safety and premises audits had not identified risks that we found in relation to the radiator surface temperatures, fixtures and fittings. Infection control and prevention audits completed every three months were ineffective because issues we found were not identified.

A maintenance book was in place for staff to report faults and repairs but it was not used properly. The last entry was made in August 2018 where it was reported that the bulbs needed to be replaced in the shower room and laundry area and kitchen. Not all previously reported issues had been marked as completed.

The registered manager gave us a copy of the action plan developed following the internal health and safety audit on the premises. Issues identified included the unsafe flooring in bedrooms, radiators without thermostatic valves and lack of detail in care plans. However, 18 of 22 action points were overdue as the completion date was not met.

Further improvements were needed to audit documentation. The medicines audit did not check whether prescribed topical creams were stored safely in bedrooms. Visual checks carried out by the registered manager and provider had not identified risks within the premises that we found.

Further improvements were needed to the care plans to ensure they were personalised and included clear and consistent information and guidance provided by health care professionals for staff to follow. Monitoring records completed by staff were not always meaningful in relation to food and drinks consumed and people provided with activities of interest to them. Records showed that people's care needs had been reviewed. However, little evidence to show that people views were sought and decisions made were not always documented.

We found the provider had not updated key documents in relation to the service. This included the provider's statement of purpose which sets out the aims of the service, management and staff skills mix, facilities within the home and the range of support people can expect to receive. The staff recruitment procedure had not been updated or followed.

The provider did not have systems or methods in place to continuously learn, and therefore improve the service. The provider's own action plan had not been monitored. Some action had been taken in response to external inspections from the local authority and Healthwatch, however, improvements were slow and were not managed or monitored.

Leadership was not effective and there was a culture whereby risks were not always recognised, unsafe practices were not challenged and a lack of oversight. Following structural changes had been made to the premises, the provider had not updated the fire and premises risk assessments. That meant staff were not

provided with accurate information and guidance to followed in the event of an emergency.

Following our inspection visit the registered manager sent us an updated action plan and regular update on the progress of the protective covers being fitted to the radiators.

We found systems were not robust regarding staff support and training. Some training for staff was out of date. The registered manager told us that training had been booked although the training dates had not been confirmed. Staff meetings were used to share information. However, meeting minutes did not show that staff were encouraged to share ideas or provided any updates on issues that were raised at the previous meetings. The registered manager assured us this would be addressed for all future meetings.

People were not always involved in a meaningful way in the running of the service. The registered manager told us that residents meetings did not take place because some people living with dementia were not always able to contribute their views. The registered manager told us surveys would be sent to people who used the service, their relatives and health and social care professionals in the new year.

The registered manager was aware of the legal responsibilities in notifying the CQC of significant events and incidents within the service. Notifications received were detailed and showed that action was taken to meet people's needs and risks were managed. The registration certificate was displayed and they were aware of the need to display the rating from this inspection. The provider did not have a website.

The service had a registered manager. People and relatives told us the registered manager was approachable and supported them when needed. Their comments about the management of the service included, "Really good." "Yes, good leadership. They are open and transparent." And, "[Registered manager] is always helpful and caring. Always answers my calls and updates me about my [family member]. There's been ongoing improvement being made to the environment which is good to see."

Staff spoke positively about the registered manager. Staff told us any issues raised with the provider and manager, had been addressed. A staff member said, "[Registered manager] is good, she listens and helps. She is very approachable; say I'm worried about someone then she will advise and tell me to call the [person's] GP and family."

The service had received cards and letters of thanks from people, their relatives and health care professionals. These were displayed on the notice board near to the entrance.

The registered manager and staff team worked in partnership with the health care professionals, commissioners from the local authority and Healthwatch. All commented on the ongoing decoration and felt people were cared for by staff who knew them well.

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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises, infection control risks and medicines were not stored safely. Regulation 12 (1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe staff recruitment procedures were not followed and checks were not carried out to protect people from unsuitable staff. Regulation 19 (3).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Safe staff recruitment procedures were not followed and checks were not carried out to protect people from unsuitable staff. Regulation 19 (3).

The enforcement action we took:

We issued a Warning Notice.