Oakley House Ltd

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Inspection report

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Date of inspection visit:
14 November 2018

Date of publication:
14 February 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?	**Requires Improvement**

Summary of findings

Overall summary

Oakley House Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Oakley House is registered to provide personal care for up to 11 people. There were five people living at the service at the time of our inspection.

This inspection site visit took place on 14 November 2018 and was unannounced.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. On the day of the inspection the registered manager was on leave so instead we were supported by the provider.

There were aspects to care delivery that were not safe. Where a risk had been identified there was no assessment of this risk with measures in place. Accidents and incidents were not always recorded onto incident forms. Staff were not always following best practice in relation to infection control. There were aspects to the environment that required improvements. We have recommended that they are always the appropriate numbers of staff available as at times they were lacking.

Staff did not always have the competencies they needed to meet people's needs and ensure their safety. Although training was being provided staff were not always providing the most effective care. People's rights were not always protected because the staff did not always act in accordance with the Mental Capacity Act (2005) MCA or Deprivation of Liberty safeguards DoLs. Mental capacity assessments were not always taking place particularly when specific decisions needed to be made. Where people had capacity, their rights were at times were being restricted.

There were times where people were not always treated with dignity. People were not always involved in the planning of their care and were not always supported with their independence. Care plans lacked detailed around the specific needs of people particularly where they had a mental health diagnosis. Improvements were needed around the activities and access to the community.

Audits and surveys were not being used as an opportunity to make improvements.There were insufficient processes in place to ensure that people were aware of how to complain. The provider was not delivering on their statement of purpose.

We saw that medicines were being managed in a safe way and there were systems in place to ensure that people were safe in the event of an emergency. There were aspects of risk assessments that were appropriate to ensure that risks to people were reduced. Robust recruitment checks were in place that ensured that only suitable staff worked at the service.

Pre- admission assessments took place before people moved in to the service. People at risk of malnutrition and dehydration had systems in place to monitor their health. People were protected from the risk of abuse as staff understood what they needed to do should they suspected abuse was taking place.

People enjoyed the food at the service and were offered choices of meals. Referrals to healthcare professionals were being completed where required and people received healthcare support when needed.

There were times where staff at the service were observed to be kind, caring and respectful towards people. People that were able could access all areas of the service when they wanted.

People had the opportunity to attend meetings to feedback on aspects of care. Staff said they felt supported and valued. We saw that the registered manager worked with organisations outside of the service in relation to people's care. Notifications that are required to be sent to the CQC were being sent.

This was the first inspection at the service. We identified seven breaches of the Health and Social Care Act 2008. You can see what action we have taken at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were not always being undertaken where there was a need. The service was not always clean and the maintenance of the environment required improvements.

We have recommended that the appropriate numbers of staff are always available to care for people.

Medicines were managed in safe way. Systems were in place to protect people in an emergency.

Staff were aware to raise concern where alleged abuse may have taken place.

Robust recruitment checks were in place that ensured that only suitable staff worked at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not acting in accordance to the MCA 2005 and DoLS. People's capacity had not been assessed before decisions were being made on their behalf.

Staff were not always competent to carry out their role and training was not always effective.

People that were at risk of malnutrition had measures in place to address this.

People enjoyed the food at the service but did not always get offered choices. People had access to health care professionals when they needed.

Pre- admissions assessments took place before people moved in to the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

There were times where people were not always treated with dignity. People were not always involved in the planning of their care and people did not always have access to an advocate.

We did see instances of staff treating people in a caring and respectful way.

Relatives and visitors were welcomed at the service. People had access to religious services that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans lacked detailed around the specific needs of people, particularly those with a mental health diagnosis.

Improvements were required around the activities provided and there was a lack of access to the community.

There were aspects to the care planning that were responsive. End of life care planning was not required at this service at the time of the inspection.

Is the service well-led?

Requires Improvement

The service was not always well- led.

Audits and surveys were not being used as an opportunity to make improvements.

The provider was not meeting their aims and objectives.

Staff were attending meetings to discuss best practice and said that they felt supported and valued.

Notifications that are required to be sent to the CQC were being done.

Staff did feedback that they thought the service was well managed. The provider worked in partnership with outside organisations in relation to the provision of care.

Oakley House Ltd

Detailed findings

Background to this inspection

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

This inspection site visit took place on 14 November 2018 and was unannounced. The inspection team consisted of two inspectors, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with the provider, three people and two members of staff. We looked at a sample of two care records of people who used the service, medicine administration and three recruitment records for staff.

After the inspection we spoke with two relatives of people using the service. We were also provided with records that related to the management of the service. This included minutes of staff meetings and audits of the service.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at the service. One person said, "There's nothing here at all that makes me feel unsafe." Another person said, "I feel I have a safety net." One relative told us, "She [their family member] seems well looked after visibly." Despite these comments there were aspects to the delivery of care that put people at risk.

People were not always protected against the risk of infection as appropriate measures were not always in place. The laundry area was not set up in a way to help prevent the risk of infections spreading. There was no separate basket for soiled washing and staff told us that they just washed the basket once it had been used for soiled washing which put people at risk of cross contamination. There was no separate area to keep clean clothes once they had been washed. The laundry room had cobwebs around the ceiling. Care staff were required to clean the service however there were aspects to the cleanliness that were not good. A commode in one of the bathrooms was dirty and stained with rust, and there was a thick build up of dust around the base of radiators. In one bathroom there was a build-up of mould and thick dust around the base of the shower. The outside of the windows in the service were dirty and carpets on the staircase were dirty and stained. There was also a torn seal around a toilet base where dirt and grime had collected.

Incidents and accidents were not always recorded and there was not always evidence of actions taken to reduce the risks of incidents reoccurring. We found that three incidents had been recorded at the service. These had been stored in people's individual care plan with no copies being kept centrally for the registered manager to analyse. Of the three accidents reports completed there was no detail on two of them about what the actual incident was, such as if the person had fallen. The third incident stated that the person fell but no detail around how this happened. None of the incident forms had information on what actions were taken to reduce further risks. The provider made us aware of another incident that resulted in the person being taken to hospital however this had not been recorded on an incident form which was part of their policy. Therefore, the service was not adhering to its own policy.

After the inspection were provided with a tracker that the registered manager used to analyse incidents. This showed that there were an additional five incidents that had not been recorded onto forms. The analysis did show however actions taken to reduce further risks.

Risks to people's care were not always managed safely. Assessments identified specific risks to people. However, there were not always detailed control measures on how to mitigate these. For example, one person was at risk of a behaviour that challenged. The care plan stated, "To monitor mental state and risk." The only guidance around this for staff was to, "Be aware of the triggers that negatively affect [person's name] mood or mental state and work to avoid them." There was no additional information on what the triggers were and what actions they needed to take. The person also required a frame to assist with walking. However, there was no falls risk assessment in place. Another person's care plan stated that they had problems getting in and out of bed and that staff, "Needed to be around" but there was no information on what actions had taken place to reduce the risk to the person or how staff should support them. Their care plan states that they have a "Historical risk" outdoors but there is not information on what the risk was and

what actions staff need to take.

Failure to safely manage risks to people is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises and equipment at the service was not always stored or maintained appropriately to keep people safe. There was a hoist at the service that was being stored in the lounge. The provider told us that no one required a hoist but they had not found an appropriate place for the hoist to be stored. The televisions in both lounges had been placed at an angle which made it difficult for the people to watch television in some areas of the room. There were fixtures and fittings in the bathrooms and people's rooms that were damaged. Radiators covers were broken and rusted in places, one person's head board on the bed was not fixed safely to their bed and in another room the skirting was coming away from the shower due to damp. There was a large groove out of the wall in one of the lounges created by a chair rubbing on the wall which had not been filled. One of the toilets that people were using had no hand towels and there was no handle on the door on the inside.

After the inspection we were notified that steps were being taken to address the loose headboard and to mend the groove in the wall in the lounge. We will check this at the next inspection.

As the premises and equipment at the service was not always stored or maintained appropriately this is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We showed the concerns with the maintenance and cleanliness to the provider on the day of the inspection and they told us that they had not picked up on this other than the cobwebs. They acknowledged that this should have been addressed.

We asked people whether they felt there were enough staff. One person said, "I think there's enough staff. Everything seems to be covered. Staff can be busy." Another told us, "There always seem to be a few members of staff there." One relative said, "Sometimes people wait a little when staff are occupied with someone. Most of the time there's someone in the office."

Improvements were required around the deployment of staff as they were unable to interact with people in a meaningful way. The provider told us that two care staff were required during the day and one staff member at night. In addition, the registered manager would also be present three days a week and sometimes more to assist if needed. However, in addition to care duties staff were also required to clean the service and cook the meals. On the day of the inspection one member of staff spent time in the morning preparing the lunch which left one member of staff to care for people for nearly two hours. Often throughout the inspection people were sat in the lounge areas without meaningful interactions from staff as they were busy with other duties.

The provider told us that in the afternoons one of the care staff would leave and often the provider would be the second member of staff. However, the provider had not received any mandatory training in relation to people's care needs. The provider told us in an emergency they would call another member of care staff to come and assist as the member of staff lived locally. They said, "I wanted to go back to having two members of staff in the afternoon." We did find however that when people required any support during the inspection staff provided assistance.

The provider contacted us after the inspection to inform us that they had a recruited a cleaner to work at the service and that the registered managers contracted hours had been increased to five days a week. They

also stated that two trained care staff would be on duty for the entire day shift.

We recommend that there are sufficient levels of staff deployed at the service to ensure that people's needs are met.

People were protected from being cared for by unsuitable staff because robust recruitment was in place. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed; with any gaps in employment explained. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

Fire risk assessments were undertaken regularly and there were personal evacuation plans for each person. This meant that in the event of an emergency or a fire there was guidance for staff on best to support the person. Staff were knowledgeable of what to do in the event of a fire. There was a service contingency plan in place in the event that the building had to be evacuated. This included moving people to another local service.

The management of medicines was being undertaken in a way safe way. Each person had an individual medicines profile with a recent photograph and a list of any medicines to which they were allergic. Medicines profiles also recorded any specific needs people had in relation to taking their medicines such as any swallowing difficulties. There were clear protocols in place for PRN (as and when) medicines, including the reason for the medicine and potential side-effects. Staff were always ensuring that the Medicine Administration Record chart (MARs) was signed when a person took their medicine. We saw that staff were competency assessed in relation to administering medicines.

There were other assessments undertaken to identify other risks to people. We saw that risks assessments took place in relation to one person's mobility. There was detailed information around them mobilising with a frame, how they needed to be supported to get into the shower and going out. Other risks that were assessed including smoking, nutrition and skin integrity.

Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff said they would feel comfortable referring any concerns they had to the registered manager or the local authority if needed. One told us, "If anybody lifted a hand to anyone then I would ring the local authority and the police."

Requires Improvement

Is the service effective?

Our findings

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 Safeguarding (DoLS).

People's rights were not protected because staff did not always act in accordance with the Mental Capacity Act. We were informed by the provider that there were three people that lacked capacity to make decisions about their care. They told us that in the morning the nurse had visited and administered a flu jab to all people that lived there. There had been no specific mental capacity assessments for those three people or evidence of any best interest discussions in relation to this. One person was having their liberty restricted despite them having the capacity to make decisions. The person smoked and staff were only allowing the person three cigars a day despite the person wanting more. The provider told us that they were acting on the wishes of the person's relative. However, as the person had full capacity the wishes of the person should have been considered.

After the inspection the provider confirmed that the person's family had power of attorney over their finances but not over their health.

There were other decision specific mental capacity assessments lacking for people in relation to staying at the service. The registered manager had applied for DoLS for three people to the local authority. However only one of these people had a mental capacity assessment and evident of a best interest meeting in relation to the locked front door. The provider told us that one relative had power of attorney of one person's health, welfare and finances but they had not obtained evidence from them that this was the case. This meant that there was a risk that the relative could make decisions on behalf of their relatives where they may not be legally authorised to do so. Although staff had a good understanding of the principles of MCA they were not always putting this into practice.

As the requirement of MCA and consent to care and treatment was not followed this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always sufficiently qualified, skilled and experienced to meet people's needs. After the inspection we were sent the training matrix for staff and saw that they were up to date with the service mandatory training. This included training in moving and handling, safeguarding, infection control and first aid. However, the provider had not received any of the mandatory training despite them working there as the second carer on some days. This put people at risk as the provider may not know actions to take in an

emergency. We found that although staff had received training this was not always effective. For example, we identified a lack of cleanliness around the service which was an infection control issue. Staff were not able to explain the mental health diagnosis of people that lived there despite this being people's primary need.

Staff did not always have supervisions to ensure they were competent to provide care safely. We asked the provider to send us their supervision matrix. According to their policy staff needed to have a supervision every three months. Of nine members of staff four should have received a supervision in October but had not. Staff told us that they felt supported however and were able to speak to the registered manager about any support they required.

As there is lack of staff training, knowledge and competency this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see aspects of the delivery of care that was effective. One person said, "Staff have experience. They work well together. They seem to know what they're doing." A relative said, "Staff are competent from what I see." We saw support people to mobilise where needed and this was done in a safe way. We saw that environment was set up to ensure that people could walk independently around the service with their walking aids. The corridors were wide and there were handrails to assist people.

Prior to moving into the service people's needs were assessed to ensure that the service was appropriate for them. Information obtained included people's medicines, any mobility concerns, nutrition and their diagnosis. People had access to appropriate health care professionals in relation to their ongoing care. We saw from care plans that people attended the dentist, GP, and opticians. One person said, "You only have to mention something and you're taken to the surgery." We saw that advice was sought from the mental health team and dieticians where there was a concern. Any advice provided by the health care professional was followed. For example, one person was losing weight. The GP recommended that the person received supplement drinks and we saw that this was being done.

We asked people their thoughts on the food. One person said, "The food is alright. I like fish and chips. I get it." Another told us, "The food is pretty good. I have porridge every morning." A relative told us, "They [people] get square meals and a variety."

There were times where people did not always have a choice of drink or meal. The provider told us that a cooked breakfast was only on offer to people on a Saturday. During the morning a person asked for a cup of coffee. The member of staff replied, "I'll bring you a coffee. Oh sorry, you've already had a coffee, I'll bring you tea." Shortly after the member of staff brought the person a cup of tea despite the person asking for a cup of coffee. One person told us when asked if they can have a coffee when they wanted, "No. We don't get a coffee after lunch. They aren't very generous are they." During lunch a member of staff came in to the dining room with three pots of yoghurt each of a different flavour. They let the person who finished first decide which flavour they wanted. They left the third person without a choice of flavour.

We recommend that people are provided with choices with food and they are involved in decisions about what they eat and drink.

People were provided with a home cooked meal for lunch. During lunch a member of staff sat with them and encouraged conversation. The member of staff asked a person, "It's nice? I hope so." The person replied, "It's nice." People were supported and encouraged to eat their meal. During the morning we saw that people were provided with drinks. There was a bowl of fresh fruit in the kitchen that people could help

themselves to.

Requires Improvement

Is the service caring?

Our findings

People and their families were not always involved in the planning of their care. The care plans we reviewed lacked detail around people's preferred routines such as what time they wanted to get up and go to bed and whether they preferred a male or female carer. One relative said, "No information was given [on the care plan]. It would be nice to know the general gist. It would be nice to know the weekly activities and the routine to encourage her [their family member]." Another told us, "No information on her [their family member] care as such was given. No weekly programme. I'm not sure about her daily routine."

The providers website states, "To ensure that service users are empowered to make informed choices regarding the various services and activities, which may be offered and made available to them. Staff ensure that service users are given the opportunity and are encouraged to exercise their right to choose to be involved in planning their care and to pursue their own interests where appropriate." We found insufficient evidence of this taking place. People did not always have an opportunity to comment on their care planning or whether their needs were accurately reflected. We saw from one person's care plan that they were to be encouraged to go to bed, "On time" which did not reflect that the person was able to choose when they wanted to go to bed.

People's rooms lacked personalisation. The rooms had been recently painted in the same colour and lacked individual furnishings such as curtains and bedding.

People were not always supported to be independent. The service websites states that they aim "To provide a supportive service in a safe and secure environment, which encourages the development and daily living skills, fosters independence, hence empowering the service user to achieve re-integration back into the community and move forward with less support." However, we found that people were not always being offered this type of support. The potential for independent living had not been realised. It had not been considered how people living at the service could be encouraged to develop their living skills such as cooking and shopping for their own meals.

Some people who needed support to express their wishes and who did not have family or friends to support them to make decisions about their care were not always aware of any advocacy services. Advocates are people who are independent of the service and who support people to make and communicate their wishes. The provider told us that they would look into this.

Lack of person centred care planning is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people whether they thought staff were caring. Comments included, "I suppose staff are caring", "If they know I'm down, they'd say something to make me feel better, like pay me compliments." One relative said, "They [staff] are very kind. They're caring towards her. The way they speak to her [their family member] there's care in their voice."

Despite this feedback we found that at times people were not always treated in a respectful way. One person told us, "Staff don't knock, they just come in [to their room]."

We observed a member of staff came in to the lounge and asked a person sat in there several times loudly whether they wanted to go to the toilet. The member of staff made no attempt to ask the person discreetly. We found that one person's sanitary items were stored on top of their wardrobe instead of in their cupboard. When we reviewed the daily notes for people we noted that these were not always written in a dignified way. For example, we saw notes that stated, "Wet himself on one occasion" and "Demanding for his urinal bottle."

We recommend that you ensure that people are always treated in a respectful and dignified way.

There were aspects of the care to people that was provided in a caring and respectful way. For example, we saw a member of staff gently wiping the mouth of a person and asking them if they had enough to drink. We saw the provider ask them if they were watching the television before they changed the channel for another person. When staff spoke with people they did so in a calming way and when people spoke with them staff listened.

When staff provided personal to people this was provided behind closed doors to protect people's dignity. People looked well dressed and had all been supported to have their hair brushed. Men were supported to have a shave if they wanted. Relatives told us that they were able to visit when they wanted however we did note from the providers website that visiting hours were restricted until 20.00 at night. The provider has since removed this from their website. We saw that people were supported to practice their religion where they wanted.

Throughout our inspection we saw staff were able to communicate with the people who lived there. On the whole staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they could understand. They also gave people the time to express their wishes and respected the decisions they made. For example, one member of staff asked a person if they wanted to sit in their bedroom or in the dining room to have their lunch. The person made the decision to eat their meal in their room and this was respected.

Requires Improvement

Is the service responsive?

Our findings

We asked people whether they felt there were sufficient activities for them to take part in. One person said, "We don't do much. We just sit here." Another told us "I go to the local hairdresser. The director takes me. I do get a lot of books. The director takes me to the library." A third said, "Staff don't take me anywhere."

There was a lack of person centred activities and engagement for people living at the service. On the day of the inspection there was no evidence of meaningful activities on offer specific to the needs of people. Those that were able could go out when they wanted. However, those that were dependent upon staff support to go out did not get as much opportunity. On the board inside the entrance hall it stated that today's activity taking place would be a "Coffee Morning" which consisted of people being served a coffee or tea and a piece of fruit. No conversation was initiated by the staff with people attending as the drink and fruit were placed in front of them. One person said, "I don't know what I'll do the rest of the morning. There's not much [to do]." The afternoon activity was listed as, "Reminiscence" but we did not see this activity take place. The activity sheet was limited to art, indoor and outdoor exercises, music therapy group reading and library/community visit. People were sat around for most of the day either watching television or asleep in the chair. We saw one person's activity records over a period of a month that mainly recorded as watched TV, walking around the garden, colouring and reading.

Activities did not reflect the current world so they were meaningful and people could use them to become more independent and feel that they were moving on or improving. For example, we did not see any computers for people's use.

There was a risk that staff were not providing the most appropriate care to people. Where a behaviour, due to their mental health diagnosis, had been identified there was not always guidance for staff on how best to support the person. All of the people at the service had a diagnosis of a mental health condition and there were no detailed care plans in relation to this. There was no clarity about how people's mental health needs would be met. Another person had a learning disability but there was a lack of detail around how this affected the person or guidance for staff. Another person was unable to see a member of their family but there was no guidance in the care plan on how staff should support their grief that they were feeling about this. One of the care plans provided detail on the activities that they undertook however this related to another person that lived in the service and had been placed in the care plan in error. The provider notified us after the inspection that this was an administrative error and that they have now corrected this.

People's daily notes were task focused rather than person centred. There were limited records of people emotional needs. In one person's daily notes we found entries that said, the daily personal care they had received and the meals they had eaten. These notes lacked person centred information such as how they felt throughout the day and what conversation topics were spoken about. This information can help provide responsive and personalised care to a person.

Care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see aspects of care that was responsive to people's needs. One person got taken to their day centre on the day of the inspection and another person was taken to get books from the library. We did see a range of activities materials in the conservatory such as colouring books, puzzles, reading books, paints and games. One person told us that new puzzles were purchased on a regular basis by the provider which they liked.

There were elements of the care plans which outlined individual's care and support. For example, there were details on people's mobility, health and dietary needs. Where there were mobility concerns identified there was guidance for staff on how best to support the person, for example, the use of walking aids. One person's care plan gave detailed information around how they were to be supported with the personal care. All of the people at the service were middle aged and no one had life limiting conditions. As such end of life care planning had not been discussed with them.

We asked people if they knew how to make a complaint. One told us, "I'd tell my mum." Another said, "I haven't had to make a complaint yet. I'd go to the manager." The complaints policy on the noticeboard in the hallway stated that if any person was unhappy and wanted to make a complaint then they should contact the CQC. There was no information on the internal complaints process. One care plan stated that, "[Person] should be encouraged to raise concerns during review meetings and resident's meetings." We reviewed the minutes of the meetings and there was no reference to discussions with people around how they could make a complaint. One person told us, "'I do complain. If the meal is not right. The shower water was not mixing. The director got the plumber and I have a new shower." We saw that the registered manager had recorded complaints and actions taken to resolve them.

We recommend that you ensure that people are made aware of the service own complaints procedures.

Requires Improvement

Is the service well-led?

Our findings

There were insufficient quality assurances in place to ensure the best delivery of care. We asked the provider if they undertook environmental checks of the service. They told us that they paid for an external contractor to undertake a full audit of the service in November 2017. However, since then they had not undertaken regular audits of the maintenance of the environment. On the day of the inspection we showed the provider the shortfalls and they told us that other than the cobwebs they had not picked up on the lack of cleanliness and maintenance.

The service's quality assurance audits were not robust and did not always identify what we had identified on the inspection. We asked to look at the infection control and cleaning audits for the service. In October 2018 their cleaning audit stated that the service was free from stains and in good decorative order. However, our findings on the day of the inspection found that this was not the case. Where an action had been identified this had not always been addressed. One cleaning audit on 11 October identified that plasticine needed to be removed from the walls. On the audit on 31 October this was mentioned again and on the day of the inspection plasticine was still on the walls.

The provider was not providing the quality of care that they aimed to deliver. The providers website stated, "We offer highly individualised and tailored care packages for service users, caring for them in a home environment. Our aim is to provide a safe, friendly and supportive home for each individual resident with a view to improving their social and psychological functioning whilst also enabling them to live as independent as possible." However, we found that this was lacking at the service and people were not always experiencing this. The provider told us that they undertook checks of the service. We asked to be provided with the last two audits that they had undertaken and were provided with one for August and September 2018. The audit looked at medicines, infection control, fire safety, the environment, staffing and people's care. Neither audit identified any concerns with the lack of person centred planning or activities, cleanliness and the maintenance of the environment.

Where meetings with people took place, action was taken to address any areas of improvement. For example, from the minutes of the resident's meetings we saw that people had requested different foods and we saw that this was provided. One person had asked for new puzzles and we saw that the provider had bought these. However, no surveys or questionnaires had been provided to people to gain feedback of their views. One person said, "There's no questionnaire. They don't find out if I'm happy." There was only one recent survey from a relative for us to review which was all very positive. The provider informed that they had not had much of a response to the questionnaires that were sent.

As systems and processes were not established and operated effectively to ensure quality of care this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives were positive about the leadership of the service. One person said of the provider, "She takes me shopping when she is shopping. She posts my letters to my sister. If I text her, she'll come." A relative said, "I met the [previous] manager a couple of times. There's been a change since. She's [their

family member] is quite happy there even though they have limited resources. She's settled." Another relative said, "I speak to the manager quite often. He's usually there. He is very amenable and supportive."

Staff we spoke told us that they felt supported by the registered manager and the provider. One member of staff said, "I would say the registered manager is a good man. He listens, he pays attention to what I say and takes actions." We saw that staff had regular meetings to discuss training, policies and the care of people. Staff were asked to feedback any areas for improvement. Staff told us that they felt valued. One told us, "I do my job the right way. I put the clients first and I get thanked."

There was evidence that the provider was working with external organisations in relation to the care provision. For example, the provider had regular contact with the GP, Speech and Language Therapists (SaLT), dieticians and other community care teams.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that people received person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that they were working within the principles of the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to ensure that people received safe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure that the environment was set up and maintained in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that the service

had robust quality assurance

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that staff were appropriately trained and supervised in their role.