Foley House Trust

Foley House

Inspection report

115 High Garrett
Braintree
Essex
CM7 5NU

Tel: 01376326652
Website: www.foleyhouse.org.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced, comprehensive inspection to this service on the 22 March 2016. The purpose of this inspection was to check that the provider had made the improvements we had asked him to make following our last inspection on the 6 January 2016. We inspected the service on the 3 and 5 June 2015. At this inspection we rated the service as requires improvement and found improvements were required in all aspects of the service provided. During our inspection on the 6 January 2016 we had continued concerns and rated the service as inadequate. We notified the provider of our escalating concerns about their failure to keep people safe and about continued breaches of the Health and Social Care Act 2008, (Regulated Activities) Regulation 2014. In January 2016 we found the service to be in breach of the following regulations: Regulation 12, Safe care and treatment. Regulation 18, Staffing, Regulation 19, Staffing -skills and competencies, Regulation 11, Consent, Regulation 9, Care and welfare of people who use services, Regulation 15, Notification of change. Regulation 17, Clinical governance, Regulation 16, Complaints.

We contacted the Local Authority who continued to monitor the service and who put a suspension in place which meant the service could not admit any new service users until the provider could demonstrate significant improvements. Following our inspection on the 6 January 2016 we served three warning notices around the most significant breaches which included Regulation 12: Safe care and Treatment, Regulation 9, Person Centred care and a warning notice under section 33 of the Health and Social Care Act 2008 for the failure to have a registered manager. There had not been a registered manager since May 2015.

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.

The warning notices served gave the provider additional opportunity to address our escalating concerns and they were given twenty eight days to comply with the Warning notices. We also met with the provider and other trustees to explain our concerns and our enforcement powers in light of escalating concerns.

We inspected the service again on the 22 March 2016. The purpose of this inspection was to follow up on the progress made towards meeting the warning notices as the date for compliance was set for the end of February 2016. However due to other concerns raised about the service we decided to carry out a full comprehensive inspection to satisfy ourselves that people were safe.

We found slow progress was being made but not in a sufficiently timely way. We did not consider everyone using the service was having their needs met or that risks to people's safety were being addressed. The provider had not made sufficient progress to be meeting the regulations at this time.

During this inspection we identified continued breaches with regulations as cited in the previous report

following the inspection on the 6 January 2016.

Care plans had been updated and there was a daily record of people's needs. However this information was not sufficiently robust. Changes in the staff team meant that not all staff were familiar with people's needs and did not always refer to the care plans to help them know what support people needed. The monitoring of people needs and reporting on changes was sporadic. Staff were not consistently filling in records or giving enough information to enable us to make a judgement about how well people's needs were being met. Throughout our observations during the day we saw staff were pushed for time and people using the service were often left unstimulated for long periods of time with very little to occupy them. The care was task focussed and risks to people were not fully mitigated as some people would be unable to call for help and staff were not often present in communal areas.

Risks to people's health and safety were not fully mitigated and risk assessments did not take into account all the risks. Where actions to keep people safe had been identified. These were not always followed through which meant risks were not clearly managed.

Staffing levels had increased but some staff were new and not yet familiar with the daily routines. Staff were not sufficiently deployed throughout the day and when the activities coordinator was not on duty staff did not offer people sufficient, meaningful occupation. The provider had introduced a dependency tool which is a means of assessing how much care and support people needed and how many staff they needed to safely provide the care. However we could not be assured of the accuracy of the tool as our observations gave us concern about how the provider was meeting people's needs. There was also a genuine difficulty in fulfilling the quota of staff the service said it needed. On the day of our inspection staff rang in sick, did not turn up for duty and there was concern about the weekend cover. This was putting additional pressure of existing staff and meant that some staff were unable to fulfil their roles properly .For example the manager and administrator were working on the floor supporting care staff rather than carrying out their own duties. Some staff had reported that some senior staff did not always support them as required. This meant we could not be assured the service was always sufficiently staffed and well managed.

We looked at medication to assure ourselves it was being administered safety and found senior staff were knowledgeable about medication and people received their medicines safely. We identified a couple of concerns about people not always taking their prescribed medicines and people being administered medicines as directed all the time. So for example where people were prescribed pain killers up to four times a day staff were administering these up to the maximum amount without always establishing if people needed them.

We looked at staffing in relation to training, recruitment and supervision. Staff training was being undertaken for all staff but we did not look at the quality or effectiveness of this training. We were concerned that staff did not necessarily have the skills or competencies to meet the specific needs of people using the service. For example staff had not had dementia training or training around specific medical conditions.

Staff recruitment was not always sufficiently robust and this needed to improve and the provider was not always following their own recruitment processes.

The care observed was appropriate to people's needs but little attention was given to people's emotional and psychological well- being. Care was not centred around the needs of individuals and not all staff were familiar enough with people's needs. Care plans gave insufficient information about people's life stories which might enable care staff to understand people's needs further. There was a plan of activities but some people were benefiting from this more than others and people's experiences varied with a number of people

feeling frustrated and unstimulated.

Some progress has been identified but is slow. There were some systems in place to check the quality and effectiveness of the service delivery but poor evidence of how people using the service were being consulted. We identified concerns at our inspection which had not been identified by the service. Roles and responsibilities were not clearly defined and staff were unclear about who they were directly accountable for.

Records were poor and it was difficult to find the information we needed or to know what the persons' current needs were and how changes had been addressed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe. Some improvement had been made since the last inspection but not enough to improve the rating.

Staffing levels had been increased but there was not always sufficient staff on duty, or staff with the necessary skills and experience to meet people's specific needs in relation to their health and welfare.

Risks to people's safety were not always identified in a timely way and we were unable to see how staff were doing all that could be reasonably expected to mitigate the risks to people.

Medication practices were acceptable but additional training and assessment of staffs competence was required to ensure staff had the necessary skills to administer medicines safety.

Is the service effective?

Requires Improvement

The service was not always effective. Some improvement had been made since the last inspection but not enough to improve the rating.

Staff were being supported through a programme of training but did not have the necessary skills and experience to meet all the needs of people using the service.

Staffs practices were not being closely monitored and formal systems of support for staff needed to be developed further.

Staff did not have sufficient understanding of the Mental Capacity Act 2015 or its application. Mental capacity assessments were not in place for people in relation to specific aspects of their care and support.

Records were in place to demonstrate how people's health care needs were being met but the standard of record keeping was poor so we could not always see actions taken to monitor people's health.

Systems to monitor if people were eating and drinking enough for their needs was not sufficiently robust.

Is the service caring?

Requires Improvement

The service was mostly caring. Some improvement had been made since the last inspection but not enough to improve the rating.

Staff were observed to be kind and supported people with their independence. However this was compromised by insufficient staffing and not all staff times were familiar with people's needs.

The care observed was task focused as opposed to person centred.

Consultation with people using the service was improving but care and support was not always provided in accordance with people's needs and wishes.

Is the service responsive?

Requires Improvement

The service was not always responsive. Some improvement had been made since the last inspection.

People did not have a programme of activity around their individual needs and people were not sufficiently stimulated.

Care plans had improved but did not always take into account changes in people's needs.

We did not look at complaints- but this was an area which required improvement at the last inspection in January 2016.

Is the service well-led?

Inadequate

The service was not well led. Some improvement had been made since the last inspection but not enough to improve the rating.

The service had no registered manager and had not for over 6 months. Staff
did not all have clear roles and responsibilities?

Record keeping was poor and we could not see how the service were always meeting people's needs.

Quality Assurance processes were poor and there were not audits for all

aspects of care and practice.

Community involvement and engagement were poor and people did not have enough contact with their community.

Foley House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 22 March 2016 and was unannounced. This inspection was carried out by two inspectors and an inspection manager and was carried out in response to on-going concerns and to see if they had made the necessary progress highlighted in the warning notices issued to the service.

As part of this inspection we looked at five care plans, spoke with four staff, observed the care and support people received through observation which included a lunch time observation .We spoke to xx people using the service. We completed a medication audit and looked at other records relating to the overseeing and management of the business.

Inadequate

Is the service safe?

Our findings

At the last inspection we identified a breach in staffing regulations as there were insufficient numbers of suitably qualified, competent, skilled and experienced persons. At this inspection we found that staffing levels were not always appropriate to people's assessed needs. The provider had introduced an assessment tool which calculated how many staffing hours were needed to meet people's needs and had made a genuine attempt to increase numbers of staff on duty.

One staff member told us when asked if there were enough staff. They told us, "Most of the time there are more staff on shift. Previously there were three now there are four." They felt that there were enough staff to meet people's needs. Another said there were usually three or sometimes two staff on each shift due to people calling in sick or annual leave. They said there were not enough staff on at night only two staff. They said if staff called in sick they relied on the acting manager or other staff to step up and cover the shift.

On the day of our inspection there were four staff, one was an agency member of staff who was not fully familiar with people's needs and, or routines and another was an apprentice. The shortfall in staffing numbers was compensated by the fact that additional staff working in other roles were able to support the care staff. The staffing rotas were not fully covered for the week ahead and in the afternoon of the inspection the manager who had already worked the morning shift had to come back on duty to cover the afternoon shift. Some staff reported staff shortages and also reported that the out of hours on call system was not always effective and they did not always feel appropriately supported.

Due to staffing levels, people's needs were not always fully met. There were no activities for people on the day of our inspection. People were left unsupervised for large parts of the day without stimulation, and little to occupy them. Staff rarely checked that people in the lounge area needed assistance. One person had a door alarm to alert people as to when they were mobile due to the high risk of falls. However we observed them leaving their room on several occasions setting the door alarm off. Staff did not respond to the alarm in a timely way as they were busy with other people which meant the alarm was not really an effective way of helping to mitigate the risks. We were also concerned about the night time support people received when staffing levels dropped to two staff. There were a number of people requiring the support of two staff with personal care. This meant that when staff were occupied with one person there would be no one to assist with other people as required and some people were unable to seek assistance using a call bell. The building is very spacious which increases the risk of someone being left unattended without the staff's knowledge.

Risks to people's safety were not appropriately managed due to the numbers and deployment of staff. This resulted in people left unsupervised. For example on the morning of our inspection we spent an hour in the lounge where six people were sitting in their chairs, the television was on with the subtitles and sound. This caused some friction between people, some people were sleeping and those awake wanted the television volume down so they could converse. No staff members came into the lounge to check how people were doing in there for the whole hour and some people were unable to call for help.

People's monitoring records did not always show us how often staff checked people particularly at night to ensure their well- being and safety. Alarms were not always responded to in a timely way which meant we were not assured of people's safety. During the day we observed two people sitting in the lounge by the front door with pendant alarms. One of them told us that they use it to call for help from the staff if they need it. The other person was unsure where theirs was but managed to find it in the end. When asked if staff come quickly when you call the buzzer the response was "Not always."
This is a continued breach of Regulation 18 HSCA (RA) Regulations 2014 Staffing.

At the last inspection we identified a breach in Regulation 12. Safe care and treatment. At this inspection we identified limited improvement but still deemed care and treatment was not always provided in a safe way. Some risk assessments had been implemented since our last inspection including an assessment of people who might be at risk of aspiration; risk assessments stated what support people needed with their meals. Other risk assessments included individual fire risk assessments which stated how a person should be supported in the event of a fire.

We looked at risk assessments but saw the service were not always assessing risk until something had occurred so the service was being reactive rather than proactive. Where risk assessments were in place they were not particularly robust neither did they take into account all the known risks which might be relevant to each situation. Risks were not being reviewed in an ongoing way, although care plans and risk assessments were reviewed monthly individual incidents were not analysed sufficiently along- side current risk assessments to see if actions taken were sufficiently robust.
The environment was clean and well maintained but we did identify risks to people's safety. We noted at one point the kitchen was left open and unattended which meant people could access it. The laundry room was also unlocked although chemicals were out of reach. Doors to the service were locked. We were concerned that the fire list which identified people's needs and support required did not tally with how many people staff told us were in the building.

This is a continued breach of Regulation 12- Safe care and treatment
Staff had received training in safeguarding vulnerable adults and staff had sufficient understanding on how to raise a safeguard, who to report their concerns to and what to record. However we were not confident that the provider had sufficient understanding of what constituted safeguarding and what they should notify the Commission of and the Local Authority. We saw safeguarding referrals had been made and investigations had been undertaken but the provider had not always reported known concerns in a timely way so they could be properly investigated. It was not clear as to the lines of accountability for reporting concerns as the provider was not always there and the acting manager had also failed to report concerns.
Medicines practices were acceptable and people received their medicines in a safe way. We looked at the administration of medicines and found that the senior carer administering the medicines was knowledgeable and people received their medicines safety. The provider told us they complete weekly audits and had also had a number of external audits and support from external agencies around developing the staff competencies. .Additional training for staff was planned as some of the initial training completed required an update. Competencies assessments were being carried out for staff administering medication. Only two staff working on night were assessed as competent to give medicines which meant there was not always someone sufficiently competent with medication on duty.

We found that the following a review of medication by the Local Authority, where poor practice had been identified, the staff had implemented positive changes to the way in which medication was administered. We found that the Medication administration records (MAR) were completed in line with the provider's policy and national guidance. Staff had completed updated medication administration training recently and

those who had not yet completed the training had this scheduled within the next two months. Where there had been a change in medicines for a person the MAR had been updated and also staff were using post it notes to remind themselves of the changes. This method of communication was effective as we saw a note that one person was due a blood test so the staff needed to delay the administration of one of the medicines. The MAR chart clearly showed that this medicine had been delayed to allow for an accurate blood test to be carried out.

Stocks of medication were as per the records managed by staff and the book used to record returned medication was up to date and accurate. However we found in the returned medication book that a large number of medicines for two people using the service were being returned every week due to the being refused. The refusal was accurately recorded on the MAR chart; however there was very little information in the person's care plan or notes in relation to highlighting these issues with the person's GP. Staff told us that they were aware that these people were regularly refusing their medication and that they were communicating with the relevant GP's but there was no evidence or record of these conversations and no instructions to staff in relation to the impact of the people not receiving their prescribed medication.

We found that a number of people had been prescribed medicines for pain relief which were to be administered when necessary. We saw and the MAR charts confirmed that people were routinely being given this medicine whether in pain or not. \for example one person's record showed that they had been prescribed paracetamol to be given as required up to eight per day. This person had been administered two paracetamol at all four medication rounds every day as far back as the MAR charts went. There were no instructions on the MAR chart or in the persons care plan to ensure that staff were aware that the medication should be administered when required.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we identified a breach of Regulation 19: Staff did not always have the necessary skills, competence and experience for their role. Staff were being supported through a programme of training but this was taking time to be rolled out. Staff attendance was dependent on there being sufficient shift cover. The training offered covered basic mandatory training. Training around the specific needs of people using the service had been identified but not yet addressed by the service. This meant that not all staff had sufficient knowledge and skill to meet the defined needs of people using the service. Staff spoken with confirmed this.

One member of staff told us that their last training session was about 2 weeks ago they were unsure what on. Staff confirmed that they had received Manual handling training and a training matrix showed us most of the mandatory training was completed or planned in the near future. Staff told us a lot of the training was done through the provider or via e-learning and we were not assured of its quality.

Some people had a sensory loss and used British Sign Language but not all staff had sign language training which meant some staff were not able to support people effectively. Other people using the service were living with dementia and did not have meaningful engagement or occupation. Staff were not consistent in their approach which meant people's behaviours/distress were not consistently responded to.
We did not look at recruitment processes but had previously asked the provider for his recruitment policy which was robust but there was some evidence this was not being properly followed in terms of recruitment of new staff. The provider had improved the induction process. We spoke with new staff who were shadowed and supported by existing staff but did not look at their records as part of this inspection.

Staff training and annual appraisal were not taking place regularly and some staff were not sure they had either. It was unclear how staff were being supported to make the improvements that were required. Staff supervisions were scheduled to take place bi –monthly.
There was a continued breach of Regulation 19, Fit and proper persons employed.

At the last inspection we identified a breach with Regulation 14: Meeting nutritional needs. Some progress was identified at this inspection. One person told us, "the food is good, not as good as my mum's she would make stew, but I can eat what I like and where I like. If I want it in my room I can. We can eat here (living room) or in the dining room. It is up to me." One person told us, "The cook is very good here."

Monitoring of people's weight, nutritional and fluid intake was in progress but was not sufficiently robust. Fluid intake was recorded but staff were not clear about how much people should be drinking or when it would be necessary to refer a person to the GP. People did not have individual fluid protocols agreed by the GP. It was not clear why it was necessary to monitor everyone fluid intake rather than assessing people's fluid intake according to risk of dehydration. Daily records were kept of people's intake but we were unsure of how accurate these records were because we observed staff giving people drinks and filing up their glasses. However staff were not recording at the time how much people were drinking or encouraging

people to drink what was in the glass.

People's weights were being recorded and some staff had completed training on nutrition. However there were gaps in the records and we could not see how the information collated was used to assess the risk of malnutrition. A record of people's food intake was in place but again it was not clear what staff did with this information when it was clear people were not eating enough for their needs. We noted that records were not filed in chronological order and it was difficult to find information needed. For example there was a monthly weight record but there was no record for December 2015. The administrator confirmed this was missing.

We observed lunch and staff supervision was sporadic. Lunch was reported to be late and not all staff were available to assist. The cook was serving and the senior was giving medication which might not have been the most appropriate time to be doing this. Medication times were recorded as 12.30 but it was already after 1.30 pm. The acting manager was helping but the dining room experience was not relaxed and some people were not eating their meal which they might have done if they received the necessary support and encouragement. One person did not eat any of their meal and staff told us their appetite fluctuated and they were not always clear why. They refused soup but was not offered anything else. We observed another two people struggling to eat the salad because it was too crunchy and they couldn't manage it with their teeth. Another person complained the chips were burnt and refused to eat them. Staff encouraged some people to eat. However, we also saw that one person left most of their meal; they were not offered an alternative because they had left the room before staff went to collect their plate. This meant that they also did not get a dessert.

This demonstrated a continued breach of Regulation 14: Meeting nutritional needs.

At the last inspection we identified a breach with Regulation 11: Consent. At this inspection some improvement was identified as staff had received some basic training in the Mental Capacity Act 2005 but still had insufficient understanding of the Mental Capacity Act 2015 or how to support people who could not fully consent. Statements about people's capacity had been made without a full assessment of their capacity. There were no decision specific Mental Capacity Assessments. A DOLS application had not been made for people being deprived of their liberty.

Where a family member had lasting power of attorney for a person this was recorded. We found people may have been being deprived of their liberty without an application being made to do so. However one person's needs were being assessed in relation to their capacity in order to better understand the impact of this. We did however, have concerns about how this persons support and care was being managed in relation to upholding their human rights.

This was a continued breach of Regulation 11 HSCA (RA) Regulations 2014 Need for consent

There was some evidence that people's health care needs were being met with regular access with the GP and District nurses. Records also showed people had access to chiropody, dental and optical services. We were passed information which showed a person was not supported with a vital hospital appointment and a subsequent appointment had not been made. Specific guidance was not always in place to manage people's health care needs such as managing the risks associated with constipations, and steps to take to minimise urinary tract infections. This lack of guidance and clear monitoring of people's health care potentially placed people at risk.

Individual manual handling plans did not take full account of the environment. Manual handling was being carried out in. So for example when we looked round there were no raised toilet seats for people with mobility issues, Wheelchairs were in the toilet blocking access to the toilet and grab rails were in the wrong position to enable people to use effectively

This was a continued breach of Regulation 9; safe care and treatment.

Requires Improvement

Is the service caring?

Our findings

Staff were mostly kind and caring but not all were familiar with people's needs.

We spoke with people about their experiences and asked 'Are you happy here' One person said, "I have to be I haven't got a home anymore so I have to make the best of it." We observed pleasant interactions between staff and people laughing and joking together. One person said, "I like it here; everybody is very nice." "You won't find anything wrong here."

We observed a carer supporting a person to get ready to come downstairs for lunch which involved getting changed and mobilising. The person found moving from bed quite painful and the carer provided appropriate physical support in line with the plan of care whilst providing constant and sufficient reassurance to ensure that the person felt safe to move. The carer noticed that the person was experiencing some pain and asked about this and offered pain relief, which was declined. The carer then supported the person to independently take care of their oral hygiene.

Care staff supporting people did so in a kind way. We saw some examples of caring interactions between staff and people but generally the care provided was functional rather than personalised care. We did see that one person who spoke very quietly repeatedly asking staff for assistance but they were not heard and ignored by staff. We could see that this was very frustrating for the person. Two staff members hoisted a person from a lounge chair to a dining chair to eat their lunch. Staff took their time with them to make sure that they were safe before transferring them.
However we noted that during lunch staffs response to people's needs was slow due to the disorganised way people were supported with their meals. One member of staff was giving out medication and staff support was not sufficient to encourage, prompt or respond to people's needs accordingly. One person pushed their food away and staff did offer them something else but no time was spent with them to establish what the problem was.

We found that care plans contained very little information about people's life history and a number of staff who were fairly new so not familiar with people's needs and not all staff were proficient in British sign language.

At lunch time we saw that there were a group of people who sat together who used sign language to communicate with each other. They were supportive to each other and there was a lot of interaction between people at the table.

There was some evidence of consultation with people using the service but no resident meetings had been planned but there was a relatives meeting coming up and relatives had been informed of the current situation within the home. There was evidence of good family involvement for some. A newsletter had also been introduced to keep people and their families up to date with what was happening at the service.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we identified people's needs were not being met in respect of their care and welfare. At this inspection we identified improvements were being made but were insufficient to be meeting the regulatory requirements. We spoke with a number of people using the service and observed them throughout the day. People's experiences of living in the service varied. One person told us they did not like living there and did not always get on with the other people or staff there. Another person indicated they were happy and were involved in the daily routines in the home and able to go out at regular intervals. Another person said they were content but when we asked them told us they spent most of their time by themselves in their room and only came downstairs for their meals. They said they spent their time watching television but was unable to watch some sports as they did not have SKY television. They told us the activities did not suit them and they did not go out. They said, "I'm happy enough but there's not much to do." One person came in for day care and a couple of people came in for respite care. However there were very few day activities provided. One person said, "I would describe this home as good." Another said "I don't like much noise so the quiet is nice, I can have the radio on if I want to listen to music, I love Jazz." When we asked one person what sort of activities were organised for them their response was "That won't take long; not much." We spoke with one person who told me that they had into town with staff at the weekend. When I asked what they had done they told me "I just looked around; I just went where they took me."

Two people were having a conversation in the lounge area. One said, "I don't dislike it here, it's not bad." The other said "I wouldn't have wanted my mother to live here." Another said,
"I would like to get up and go to bed for a while, but I can't" "I am hoping not to be here much longer." "I would like a cup of tea or a biscuit, but I can't get up to get one. Hopefully it will be here soon." One of the people called out frequently for staff but no member of staff was in the immediate vicinity so their calls were not answered. They asked us several times to assist with different things.

The home had insufficient activity for people. The provider said 40 activities had been planned for February/March but not all these had taken place. There was a person employed specifically to provide activities and there was some evidence that these took place and some people using the service benefitted from more activity than others. Trips to the local community had been planned and taken place to help relieve the frustration and boredom experienced by some but these were not regularly planned. On the day of our inspection there was no one providing activities and nothing planned. We observed people sitting all day with nothing to occupy them except television in the communal area which no body watched. There was an absence of genuine stimulation for people or a real attempt from care staff to interact and spend meaningful time with people. Staff were busy throughout the morning and people were left to their own company. This was difficult and some people used sign language to communicate but this service is not exclusively for people with sensory loss so some people were unable to communicate with others. For example we saw one person talking to a person who in response signed back. The person nodded their head and told them they could not understand what they were saying. They approached another person who told them to go away. The person walked away and was observed to become increasingly frustrated as the day went on.

The activities co-ordinator works for a total of 12 hours a week. This includes 2 hours a week when they escort a person living in the service to an organised external activity. These 2 hours were paid for privately by this person. One member of staff told us that last week they went around and asked people if they would like to have their nails painted. But that then they couldn't do it because they were pulled away to assist with personal care. "There are not enough one to one activities in the home."

"I would like to be able to sit and talk with people and do one to one activities; this is how you really get to know people. But there is no time." Staff knew what people liked to do e.g. one person likes to be read to – this doesn't happen very often because there is not enough time to do it.
Activities recorded in the diary over the past 2 weeks were sampled and did not show a great deal happening or activities exclusive for everyone.

There was a newsletter and a designated activity room with materials people could use to create art work. There were some photographs of activities which had taken place and staff told us of some things they had done with people. This needs to be developed further and be more inclusive of people's individual needs and interests.

We looked at peoples care plans which had been revised since our last inspection. These were improved and told us what people's needs were in relation to their care and welfare and risks to their health and safety. Some but not all care plans included information about person's preferred night time routine including the time that they liked to go to bed, where to place their pendant alarm and that they liked to have their light on at night. The person confirmed that this was put into practice by the staff.

Daily notes were in place recording people's needs on a daily basis but these were not sufficiently robust and did not always tell us how people's needs were being met. Records were not being used in a consistent way or demonstrate how care was being delivered effectively. For example records showed people should be monitored hourly for their safety at night. However the rationale for this was not clear in people's care plans or reflective of people's individual needs. Monitoring records were not filled in consistently so we could not see if the checks were happening or not. Food and fluid records were not completed contemporaneously so we could not be sure of their accuracy. Risk assessments had been updated but monthly rather than in light of an incident or fall. The staff were not proactive in managing risk, but were reactive. At our last inspection we raised a safeguarding alert in relation to a person with no risk assessment despite risks being present. This meant risks to them were not being effectively managed. The provider subsequently put in place a risk assessment but this was a week after us raising concerns. The actions taken to reduce risk were not sufficiently robust or effective as staff were not following the risk assessment. Risk assessments did not take into account all the factors which might increase a risk to a person's safety. For example a number of people regularly refused their medicines. This was a risk. Other people were taking sedatives which were also a risk in terms of falls. Missed medications were being recorded and reported but it was not clear what actions were being taken.

This demonstrated a continued breach of Regulation 9.

At the last inspection we identified a breach with Regulation 16, complaints. We did not look at complaints as part of this inspection.

Inadequate

Is the service well-led?

Our findings

At the last inspection we identified a breach with Regulation 17: Good Governance which states there need to be systems in place to assess, monitor, and improve the quality and safety of the service. At this inspection we saw some improvements had been made but was slow. The staff spoken with said they felt well supported by the acting manager but less so by some of the other staff. The acting manager was clear with us that their priority was to support staff and build morale. However staff did say it was difficult for them to know who was doing what. They felt that having both the provider and acting manager to answer to resulted in conflicting information and they were not sure who they should report to. Staff also felt that not all the staff pulled their weight on shift or prioritised the care given to people over the paperwork. They said this caused tensions.

Steps were being taken to support and develop the staff team but some staff did not have the necessary skills and competencies to undertake specific tasks. Staff were being supported around these areas to enable them to take on additional responsibilities. For example some senior staff lacked experience to do staff supervision and staff appraisals so these were being shared out between the acting manager and provider which meant progress was slower than it would be if all staff were sufficiently trained.

Records in the service were difficult to find and were not maintained in chronological order and where documents were more than one page these were not stapled together. Some records requested could not be located and it was difficult to find the most up to date record and some records had not been archived. Information kept about people's needs was not particularly robust and did not demonstrate how people/s needs were being met. For example a person coming in for day care had not had their care plan/record updated for many years so it was not possible to see if there had been changes to their needs. Records in people's files contained generic statements rather than being based around individual need. One such record included someone else's name and it was unclear as to their main needs.

The service had not been notifying us of event affecting the well-being and, or safety of people using the service. This meant we were unable to respond to information of concern in a timely way. When we spoke with senior staff they were unaware of what they needed to notify us of and there were not clear lines of accountability roles or responsibilities within the staff team. We were alerted to concerns which had involved the police and where a person's health and safety had been severely compromised. The service had failed to notify us of this.
This is a breach of the Registration Regulation 2009- 18- Notifications
Some staff had specific responsibilities but when staff shortages occurred they were required to provide direct care. This included the acting manager which meant they did not always have sufficient time to manage the service.

The provider did not have an overview of people's needs and the main risks to their health and safety. Accident and incident records were completed and put in to individual records and information was not being consistently recorded to a high standard. We could not always see what actions had been taken as a

result of an accident, incident or fall to mitigate the risk or reduce the overall number of incidents, accidents occurring at the service.

Policies and procedures had been developed underlying good practice but staff spoken with were not aware of actions they should take in some instances such as if people were not eating/drinking enough or how much people should be drinking. It was also clear that some staff were not referring to people's care plans to help them know what people's needs were and how they should be delivering care in a consistent way.

Some improvements had been made in terms of the safety of the building such as revised generic risk assessments and individual fire risk assessments. There were still some identified risks to people's safety which were not being effectively managed due to the size, and complexity of the building and adequate staffing of it.

This meant there was still a continued breach of Regulation 17 HSCA (RA) Regulations 2014 Good Governance.

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 was not maintaining a suitable record to show how they were assessing and evaluating people's care to ensure it was appropriate to their needs. Regulation 9 (a) (b) (c) 3 a-I.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring that people always received safe care and treatment. They were not fully assessing risks to individuals or risks arising from the environment. Regulation 12- 1, 2 (a) (b) (c) (d) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider was not fully meeting people's dietary and hydration needs as systems in place to monitor this were inadequate and did not fully mitigate the risks. Regulation 14.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints We could not see how complaints were resolved and to the satisfaction of the person raising the concern. Regulation 16 (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A) The provider did not have adequate systems in place to assess, monitor and improve the service. B) It did not assess, monitor and mitigate risk C) It did not maintain a contemporaneous record in respect of each service user. D) It did not maintain records securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure all staff had the necessary skills and competencies. Regulation 19 (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not maintaining sufficient numbers of suitably qualified, competent, skilled and experienced Persons must be deployed in order to meet the requirements of this Part. Regulation 18 (1) (a)

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 18 Registration Regulations 2009 Notifications of other incidents The provider must notify us of incidents as defined by the Act. Regulation 18 of the registration regulation 1. 2 (a) I, II, III Iv

The enforcement action we took:

warning notice