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Summerlands

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 18 and 19 January 2017 and was unannounced. A previous inspection undertaken in December 2013 found there were no breaches of legal requirements.

Summerlands is a privately owned care home close to the centre of Southsea. It comprises of a large Victorian villa situated in its own grounds. Accommodation is spread over four floors, with stair lifts between some of the floors. It is registered to provide care for up to 23 people some of who are living with a learning disability or autistic condition. The home is not registered to provide nursing care.

The home had a registered manager registered with the Care Quality Commission (CQC). However, we were told this person had recently left the home and was in the process of cancelling their registration. A registered manager is a person who has registered with the 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. An acting manager had just commenced employment at the home. We were supported by the acting manager and deputy manager throughout the inspection.

Window restrictors at the home did not meet current guidance for care homes, as set out by the Health and Safety Executive, meaning there was a risk of people falling. The temperature of the water from some taps and showers was above 50 degrees Celsius. This presented a potential scalding risk to people who used the service. The provider wrote to following our visit and confirmed that these issues had been addressed. Some areas of the home were not always clean and showerheads had lime scale on them.

Checks on people's finances, both their day to day money usage and longer term financial accounts were not robust. There were no independent checks on some accounts. We have spoken to the local safeguarding adults team about this and the provider has written to us to say these processes will be changed. The provider was following local safeguarding processes and reported other types of concern to the local safeguarding adults team. Staff had received safeguarding training.

Medicines were not always managed safely and effectively. There were gaps in medicines records and medicines care plans were not always detailed or up to date. The acting manager was making changes to the storage of medicines, which they had identified as being inappropriate.

Proper recruitment procedures and checks were in place to ensure staff employed by the service had the correct skills and experience and there were sufficient staff available to support people's care needs.

Staff told us they had undertaken a range of recent training and updating, although the training records were not always clear and some areas of training were out of date. Staff had regular supervision sessions, but it was not clear from records if annual appraisals had been undertaken. we have made a recommendation about this.

One person had been subject to a DoLS order under the MCA (2005), although the CQC had not been notified of this in line with legal requirements. Some people had signed their care plans to say they consented to the delivery of care, although it was not always clear if they fully understood what they were signing. We have made a recommendation about this.

People had access to health care services to help maintain their wellbeing. There were regular visits to general practitioners and other health and social care professionals. Advice from such interventions was incorporated into people's care records.

People were supported to access adequate levels of food and drink. Specialist advice had been sought, where necessary, and guidance followed.

We observed there to be good relationships between people and staff. People looked happy and relaxed in staff company. Relatives told us they were happy with the care provided. People's dignity was not always respected. We saw milk was placed directly in the teapot and a person on a softer diet did not have food that was served appropriately. People were being supported by independent advocates, as necessary.

Some care plans had good personal information about the individual and their particular likes and dislikes. Care records were not always up to date and risk assessments were being used to deliver care, rather than care preferences agreed with the individual. Reviews of care and risk assessments were not always timely or detailed. Changes to care delivery were not always appropriately recorded.

People were supported to attend various events and activities in the local community.

The acting manager told us there had been no formal complaints in the last year and relatives told us they had not raised any recent concerns.

Regular checks and audits had been carried out on the service by the previous registered manager, although the findings of these audits were different to the situation we observed at this inspection. Checks by the registered manager and the provider were not robust. Policies and procedures did not reflect current regulations. Staff were positive about the leadership of the new acting manager and felt she was making timely and appropriate changes. The acting manager advised us of a range of issues she felt needed improving and addressing and demonstrated some of the changes she wished to introduce. Staff told us there was a good staff team and felt well supported by colleagues.

Subsequent to the inspection the provider wrote to us and informed us that many of the shortfalls identified at the inspection had been, or were in the process of being, addressed.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the Safe care and treatment, Safeguarding people from abuse, Dignity and respect and Good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Window restrictors that met current guidance were not fitted. We recorded water temperatures that were above 50 degrees Celsius. Medicines were not always managed and recorded safely.

Staff had undertaken training on safeguarding issues and recognising potential abuse. Appropriate systems to support people to manage their finances were not in place.

Risk assessments had been undertaken in relation to the environment. Accidents and incidents were recorded although not always reviewed and monitored.

Proper recruitment processes and staffing levels were maintained to deliver individual care.

Is the service effective?

Requires Improvement ●

The service was not always effective.

A range of training had been provided and completed, although records indicated some areas of training were overdue. Regular supervision was undertaken. It was unclear if annual appraisals had taken place and been appropriately recorded.

The registered manager was aware of the Mental Capacity Act 2005. One person had been granted a DoLS. People had signed consent forms, although it was not always clear they had the capacity to do so.

People were supported to maintain adequate levels of food and drink. People were supported to access health and social care appointments.

Is the service caring?

Requires Improvement ●

The service was not always caring.

We observed good relationships between people and staff.

People looked happy and relaxed in staff company.

Relatives said they were involved as much as possible in care reviews and decisions. People were supported by advocates, if required.

People's dignity was not always protected through staff actions.

Is the service responsive?

The service was not always responsive.

Care plans and risk assessments were not always up to date, well maintained or appropriately reviewed.

People were encouraged to engage in a range of activities and events and had regular access to the local community or local day care centres.

There had been no complaints in the last 12 months.

Requires Improvement ●

Is the service well-led?

The service was not well led.

Checks and audits of the home and people's care were not robust and did not reflect the issues found at this inspection. Records were not always complete or well maintained.

The provider had failed to notify the CQC of a person having a DoLS order granted.

Staff talked positively about the support and leadership of the acting manager. They said they were happy working at the service and there was a good staff team. Staff meetings had taken place and staff told us they could actively participate in these.

Requires Improvement ●

Summerlands

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 18 and 19 January 2017 and was unannounced. This meant the provider did not know we would be inspecting the home on these dates.

The inspection team consisted of one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. We reviewed information we held about the provider, in particular notifications about incidents, accidents, safeguarding matters and any deaths.

Not all the people using the service were able to communicate with us in detail, but we spent time observing how they interacted with staff at the home and spoke with three people. We also spoke with a relative who was visiting the home during the inspection. We spoke with three members of staff, the acting manager and the deputy manager. We also spoke on the telephone to a social worker for a person living at the home. Following the inspection we spoke with two relatives of people who used the service and the local safeguarding adults team. We also contacted four health or social care professionals, seeking their views of the service.

We reviewed a range of documents and records including; three care records for people who used the service, 13 medicine administration records, three records of staff employed at the home, complaints and compliment records, accidents and incident records, minutes of meetings, communication documents and a range of other quality audits and management records.

Is the service safe?

Our findings

During our inspection we noted a number of safety issues at the home related to the property and equipment used. On the first day of the inspection we saw windows on the upper floors of the building did not have window restrictors in place that met current Health and Safety Executive (HSE) guidance. Some windows had inappropriate restrictors in place whilst others had no restriction on their opening at all. Several of these windows opened on to immediate drops. One person's room had patio type windows which, despite having some form of restriction in place, opened beyond the required 100mm and immediately on to a flat roof area which also led to an immediate drop. We spoke with the acting manager and deputy manager about this. They told us they were not aware the current systems were inappropriate and would make arrangements with the provider to have suitable restrictors sourced and fitted. This meant there was a risk of people falling from height because proper safety systems were not in place. The provider subsequently wrote to us to inform us appropriate restrictors had been fitted to the majority of windows at the home.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

On the second day of the inspection, during our walk around of the home we looked at the bathing and washing facilities available. We ran our hands under the taps to test the temperature of the water. We found it was extremely hot. We tested the temperature of the water and noted in most of the bathrooms and toilet areas the temperature recorded was above 50 degrees Celsius (The maximum the thermometer would record). Health and Safety guidance requires water temperatures for such outlets are maintained below 44 degrees to prevent scalding.

We also checked hand basins in some people's rooms and found water in these areas was also above 50 degrees Celsius. We asked a member of the domestic staff to check our findings and they agreed with them. We spoke with the acting manager and deputy manager about this. The acting manager told us the previous registered manager had checked the temperatures the week before the inspection and found there were problems. She understood she had intended to speak with a plumber, but was not aware she had done so. They said they would speak to the provider about a plumber attending the home to deal with the matter. The deputy manager later told us the provider had contacted a plumber who would be attending the following day to fit temperature controlling valves on all outlets. This meant there was a risk to people of scalding because water temperatures in sinks and baths were not regulated. The provider subsequently wrote to us to inform us special valves limiting the water temperatures for each tap had been fitted.

Whilst examining bathrooms and toilet areas we noted flooring in some of these areas was badly stained and loose at the edges, meaning it could not be cleaned effectively. We also noted showerheads and taps in some rooms were encrusted with lime scale, which can increase the risk of infection spreading. We spoke with a member of the domestic staff who told us showerheads were cleaned every two weeks. We spoke with the acting manager and deputy manager about our findings. The acting manager told us she had already spoken to the provider about the flooring and this was to be replaced. The deputy manager later

told us the domestic staff member had informed her they had run out of cleaner for the shower heads, but had not immediately informed anyone. The provider subsequently wrote to us to inform us plans were being advanced to renew the flooring in the bathroom areas.

A small number of people living at the home occasionally used a commode in their room during the night. We noted the home did not have sluice facility. We asked the acting manager and deputy manager how this equipment was cleaned and disinfected. They told us the commodes were emptied into the toilet in the nearest bathroom and then cleaned whilst being held above the toilet. The acting manager said that once a week the commode pots were taken to the laundry area and soaked in a solution. This meant there was a risk of cross contamination because commode equipment was not being cleaned in line with best practice guidance about the decontamination of such equipment, and, it was being cleaned in a bathroom environment or in the laundry, where there were clean clothes. We advised the acting manager to seek further advice from the local infection control team. The acting manager told us they would cease to use commodes in all but the most emergency situations.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

We looked at how medicines were managed at the home. The acting manager told us she had already identified issues regarding the storage of medicines at the home and also processes for the ordering and disposal of unused medicines. We saw new metal cabinets had been obtained to move medicines out of the kitchen style cabinet they were currently stored in. The acting manager also explained the new system in place for the ordering and returning of stock, to ensure proper checks were in place.

We looked at people's medicine administration records (MARs). We found there were several gaps in the MAR documents, meaning we could not be sure people had received their medicines. We noted one person was prescribed a specific cream for a skin problem. The cream was to be applied twice a day. We saw that for the whole of the previous month the person was recorded as being asleep in the morning and had refused to have the cream applied in the afternoon. There was no indication staff had returned and offered the medicine when the person awoke and no indication advice had been sought from a doctor or health professional about the consistent refusal of the cream. Some people were prescribed medicines that could be taken in variable doses. Some of these medicines had a maximum dose that should be taken in any 24 hour period. Because the amount of medicine given was not always recorded it was not possible to be sure this maximum dosage was not exceeded.

We twice observed staff administering medicines. On the first occasion we noted the staff member did not always stay with the person to ensure they had fully taken their tablets, but returned to the record book and marked the medicines as taken. Whilst we saw the person did take their medicines, this was not directly observed by the staff member. On the second observation we saw the staff member took time to stay with the person and ensured tablets and medicines had been swallowed before marking them as administered. The provider subsequently wrote to us to inform us new systems were in place for the monitoring of medicines and staff training around the safe handling of medicines had been up dated.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

The deputy manager told us there had been two safeguarding incidents at the home in the last 12 months. We saw these had been recorded, the local safeguarding authority contacted and action taken to investigate or manage the issue. The deputy manager told us the provider had deputyship for eight people who used

the service. Deputyship is a formal arrangement which allows a specific person or organisation to manage people's financial concerns when they do not have the capacity to do so themselves. Each person had their own account documentation on the home's computer system. We asked what checks and safeguards were in place to ensure the accounts were managed safely and effectively. The deputy manager told us there was no independent scrutiny of these accounts, with the exception of an annual oversight check by the local authority contracts team. This meant there was no effective and robust checking to ensure accounts were handled safely.

We noted one person, whose finances were supported by a relative, had paid a sum of money as a contribution to a door entry system at the home. The deputy manager told us the person's relative had agreed this contribution directly with the provider. We could find no evidence to show the relative had any legal authority to make this decision. We spoke with the relative ourselves, who told us they thought they had some sort of responsibility, but was not entirely clear. We spoke with the person's social worker who said they were not aware of this payment and said it should not have been agreed.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 13. Safeguarding service users from abuse and improper treatment.

The deputy manager said there clearly had been a misunderstanding and the money would be returned to the person's account. The person's social worker said they would review the financial arrangements for the individual concerned. We have spoken to the local safeguarding adults team about the limited oversight and they will look further into this matter.

The provider subsequently wrote to us to inform us money paid in error by a person to the service had been refunded in full. The local safeguarding adults service were also going to review the accounts of all people at the home whom the provider held deputyship for.

Certificates for equipment used at the home and safety check certification was in place. For example, we saw copies of Lifting Operations and Lifting Equipment Regulations (LOLER) certificates for hoists and lifts used at the home, gas safety certificates and five year fixed electrical certificates. We saw copies of the home's asbestos survey and legionella testing results, which were clear. Risk assessments were available for the use of chemicals or the risk of slips and trips on leaves in the autumn. COSHH (Control of substances hazardous to health) information was also available. A food hygiene rating visit by the local food standards inspector, in October 2016, had given the home's kitchen a five star rating (the highest available). Risk assessments, such as the risks associated with going out in the community, were included in people's care plan documentation, although these were primarily incorporated into the care planning process.

During the planning of the inspection we noted the local Fire Brigade had previously required action from the home to ensure fire regulations were met. The deputy manager told us the Fire Brigade had returned to the home and confirmed the required improvements had been made. We saw a new fire risk assessment had been undertaken in 2016. There were no significant issues highlighted in the assessments. We saw there were regular checks on fire systems and equipment, both internally and by an outside contractor. Regular fire drills had also been undertaken. People had individual personal evacuation plans (PEEPs) which detailed the support they may require in the event of an emergency. Fire evacuation notices were displayed throughout the building. We noted these were not in an easy read or pictorial form. We spoke with the acting manager and deputy manager about this and they said they would look to develop these as part of the overall review of work.

The acting manager told us there were three staff on duty during the day shift and two waking staff during

the night. Staff duty rotas confirmed these staff numbers were available. The acting manager told us both she and the deputy manager were available during the day. An on call system was available for staff to seek advice at the weekend and at other time out of normal office hours. People, relatives and staff told us this was sufficient to support people's needs. Staff told us a number of people living at the home regularly went to days centres during the day.

We looked at personnel files for staff currently employed at the home. We saw an appropriate recruitment process had been followed, with two reference requested, identity checks and Disclosure and Barring Service (DBS) checks undertaken. DBS reviews ensure staff working at the home have not been subject to any actions that would bar them from working with vulnerable people.

Accidents and incidents were recorded in people's files and appropriate action had been taken to deal with each individual incident. It was not clear from records that there was an overall review of accidents and incidents to identify any trends or recurrent causes. The manager said she would be including reviews of such matters as part of her updated management programme.

Relatives we spoke with told us they felt their relations were safe at the home. One relative told us, "I can sleep at night knowing they are safe and looked after."

Is the service effective?

Our findings

Staff told us they had received training in recent months. They told us the home used a predominantly book based system that they could take away and complete at home. They felt this was good as it allowed them to complete the training around their personal commitments.

The acting manager and deputy manager showed us the training matrix held on the home's computer system. The matrix had dates which indicated the majority of staff had completed training considered mandatory by the provider such as: emergency first aid, health and safety, infection control and moving and handling. Mandatory training is training that is required to be undertaken at regular intervals. A small number of staff had dates assigned to their names which indicated training had not been recently updated. The acting manager told us she was in the process of revising the training system at the home and would be introducing a more comprehensive monitoring and reviewing system in the near future. She told us any specialist training, such as percutaneous endoscopic gastrostomy (PEG) feeding or stoma care would be delivered by district nurses to the staff and the district nurses would ensure staff were competent. A PEG is a tube that goes directly into a person's stomach where they cannot eat normally or can only take a limited amount of food orally.

The acting manager told us new staff were subject to an induction process and would also be allocated shifts to shadow a more experienced member of staff. The manager and acting manager told us one recent recruit had completed the Care Certificate as part of their induction. The Care Certificate is a national set of standards that care workers are expected to meet before fully providing support and care. They said they were both participating in training on the Care Certificate in the near future, in order to be fully briefed about the implications and benefits of this approach. This meant the provider had an appropriate system in place to recruit staff.

Staff told us they received regular supervision, approximately every three to four months. We saw evidence supervisions had taken place and staff had the opportunity to contribute to the discussions. We saw staff had discussed any work issues they wished to raise, future training needs and any personal matters that may have impacted on their work commitments. Staff and the registered manager had both signed the supervision record to say they were correct.

Staff told us they were unsure as to whether they had had an annual appraisal. Some staff felt the regular supervision sessions may have covered the annual appraisal, but other staff felt this was not the case. The acting manager and deputy manager felt appraisals had routinely been part of the supervision process conducted by the previous manager. However, we found copies of appraisal documents in staff files, some of which were undated and none of which were signed by staff to say they agreed with the appraisal process and outcomes.

We recommend the provider establishes a robust system for undertaking and recording staff appraisals.

The provider subsequently wrote to us and told us the acting manager was introducing a new supervisions

and appraisal process.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The acting manager told us only one person living at the home was subject to a DoLS. We saw the correct paperwork was in place and the DoLS had been reviewed and renewed, when required. We noted the provider had not notified the Commission that a DoLS had been granted, as they are legally required to do so. The acting manager and deputy manager were unsure why this had not occurred. The acting manager told us she would ensure a notification was made to the Commission as soon as possible and later confirmed this had been done.

We noted some people had signed their care delivery plans to say they agreed the care that was planned to be delivered. However, the care plans often used involved language that would not always be accessible to people with a cognitive disorder. There was no assessment in place to confirm people had the capacity to understand what they were signing. The acting manager told us one relative had a lasting power of attorney (LPA) for a person living at the home. LPA is a legal process granted through the Office of the Public Guardian that permits designated individuals to make decisions on people's behalf, if they did not have the capacity to do so themselves. However, the home did not have a copy of this document for reference to ensure any decisions made were within the legal arrangements.

During the inspection the acting manager told us a best interests decision was in progress. This discussion had involved the person, their relatives, staff from the home and the person's social worker. The discussion had considered whether the person would be able to move to another part of the country to be closer to relatives, and whether it was in their best interests to do so. The acting manager told us a final decision had not been made and further considerations and discussion would be taking place. This meant appropriate processes were followed to conduct a best interest decision, where people may not have the capacity to make decisions themselves and a LPA was not in force.

We recommend the provider and ensures appropriate measures are in place to monitor and confirm capacity and authority for people, or their relatives, to consent to care at the home.

People we spoke with told us they liked the food and enjoyed the meals provided at the home. We spent time observing meal times at the home and saw regular meals were well presented and there were good portions available. Some people attended day centres during the day and so took a lunch box with them. For these people, meals from the midday menu were plated and chilled and they received a cooked meal in the evening.

We spoke with the cook working at the home. She told us she knew most people well and their likes and dislikes. We noted there was only one main meal offered on each day. The cook said people were aware what the meal was and if they preferred an alternative they would come to her in the morning and ask for something different. On the second day of the inspection we saw the cook was preparing sausages and

chicken for people who had requested a different meal to that on offer. The cook was aware of people with particular dietary requirements, such a soft diet or the need to have a controlled diet because of diabetes. There was information available about people's particular needs or preferences.

There was evidence in people's care records they had regular contact with general practitioners, physiotherapists and other health professionals. Several people were seen regularly by a member of the local district nursing service and people who had stomas or PEGs were also seen by specialist support staff. One person, who was supported with stoma care told us, "Staff help me with the bag I have on my tummy." Some people living at the home could present with behaviour that could be described as challenging. We saw where this was the case support had been sought from the local behaviour support team. This showed the provider supported people's health and welfare.

Staff and the deputy manager told us many people who lived at the home had done so for a number of years. They were aware people were getting older and this often impacted on their physical ability to manage stairs. To support people within the home environment a number of stair lifts had been fitted to allow people to access the various levels of the building. We saw people used these on a regular basis.

A number of people living at the home had cognitive difficulties and did not always understand or recognise written language. We saw there was limited use of visual or easy read information, such as visual signage for bathrooms and toilets, visual fire evacuation signs or visual representations of daily menus. The acting manager told us she was aware of this and would be looking to address the matter as part of the overarching improvements to the home.

Relatives told us that although they felt the home was generally clean, they also felt the decoration was now looking "tired" and in need of some updating.

Is the service caring?

Our findings

We found people's dignity was not always supported at the home. Whilst we were observing the tea time meal, on the first day of the inspection, we saw staff had added milk to the tea whilst still in the teapot and everyone was provided with tea with milk in it. This meant people did not have opportunity of adding their own amount of milk or deciding if they wished to take milk at all.

One person was receiving support with a soft diet. National guidance states that where this is the case individual food items (meat, potato, vegetable) should be presented as separate items on the plate. During the tea time meal we saw the person's meal was presenting as a single bowl of food. We also noted that during one meal time a person, in the middle of eating their lunch, was approached by a staff member to apply a pain relief gel to their legs. The person was required to stop eating their meal, roll their trousers up and sit in the middle of the dining room, whilst staff applied the cream, in full view of other people. A relative we spoke with following the inspection told us they had spoken to staff about their relation attending an appointment in a dirty coat, which they felt was inexcusable. They said the staff member who was also there had apologised and the coat had been washed later.

We spoke with the acting manager and deputy manager about these incidents. They both agreed these events did not support people's dignity. They said they would speak with staff about the events and remind them of the importance of ensuring people's dignity at all times. The acting manager showed us moulds that had been bought for the person on a pureed diet. She told us the intention was to improve the presentation of the food, even though it was softened, but they were currently waiting on additional thickener to do this.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 10. Dignity and respect.

Following our inspection the provider wrote to us and told us staff had been reminded about the importance of respecting people's dignity. She told us milk was no longer placed in the teapot as a matter of course.

We noted a number of people living at the home shared bedrooms with other people, who were not their relatives. The deputy manager told us these people had lived at the home for a number of years and had always shared accommodation and were now quite attached to the people they shared with. She told us they had approached people who shared accommodation when a single room became available, but they preferred to continue to share rooms as a matter of choice. The acting manager told us that going forward it was the intention of the provider to develop the service into a single roomed facility. She said she had already agreed with the provider the current twin room with a vacancy would not be filled. We spoke with people who shared their rooms. They told us they liked sharing their rooms and enjoyed the company of others. We saw there were good relationships between people who shared rooms and there was an obvious fondness between them.

We recommend people's care needs and preferences are regularly reviewed to ensure shared facilities continue to be an appropriate preference and approach for people living at the home.

The acting manager told us that no person in receipt of care had requested support with issues of equality and diversity; such as issues around race, gender, religion or ethnicity. A number of people were supported to attend local churches. People talked enthusiastically about a church group that came to the home every week. They told us they really enjoyed this event and were evidently looking forward to it.

We asked people if they liked living at the home and they indicated they did. People commented, "The staff are all lovely"; "I like living here. I have lots of friends here" and "All the staff are nice." Relatives we spoke with told us, "It's very good here. The staff are lovely. They couldn't do enough for (name of person)"; "I feel that they are fairly well settled, to my own amazement. It is proving to be the right place for them. They would have some sort of reaction if they were unhappy and there hasn't been"; "(Name) is very happy there. The staff are really lovely with her. (Name) loves the staff" and "I would say they are really caring staff. (Number of staff names) in particular are really caring, particularly (staff name). On the whole they seem very happy there."

We spent time observing the relationships between staff and people. We saw these were good with lots of friendly and supportive exchanges. All staff, including domestic staff, took time to speak with people as they were passing. Staff would ask people if they were alright and enquire if they were going out, or enquired how their relatives were. One person was enjoying a joke and some light-hearted banter with some staff and told us that they, "Had to keep the staff in order", but then smiled broadly and laughed.

There was some evidence in people's care records they had been involved in making decisions about their care. Relatives we spoke with told us, "I am very involved in care. I'll often get a phone call or they will speak with me if I pop in." We were shown copies of a 'service user satisfaction questionnaire' for 2015 – 2016 that had been given to people living at the home. The majority of the replies were undated, although some were dated as 19 October 2015. There had been some attempt to make this an easy read document, with the addition of pictures, but in the main the questions were long and involved, with simple 'Yes' or 'No' answer boxes. The responses were positive about the service. The acting manager showed us a revised version of a questionnaire she was about to send out. This had increased use of pictures to illustrate question areas and used a range of smiley/sad faces for people to choose a response from. There were two relative questionnaires from July 2016. These were also simple 'Yes/ No' questions, although the responses were overwhelmingly positive about the service.

The manager told us some people were supported by advocates, although many people had relatives close by who would support them and represent their views, if necessary. On the first day of the inspection the manager and deputy manager held a meeting with a person and their financial advocate. This was to help the person sort out their personal finances and we saw the advocate was going away to look further into some matters for the individual. This meant people had access to independent advice and support, if they required it.

People's independence was supported. They were supported to go out into the community, attend local events and keep in contact with friends and relatives. People's rooms contained photographs and ornaments that were important to them. Several people attended day services away from the home. People were also supported and encouraged to keep their own rooms tidy. A number of people regularly went out to purchase a daily paper or obtain a weekly magazine.

Is the service responsive?

Our findings

People living at the home had personal care plans in place. These records were separated into care delivery plans and risk assessments. The care plan element of the records contained some good detail about people's backgrounds and personal preferences. However, in the majority of cases the risk assessments were used as the basis for people's care. This meant the delivery of care, which had been agreed with individuals, was not always reviewed in a timely manner. Some care records had not been reviewed since 2015.

Risk assessments were reviewed on a monthly basis, although the detail contained in the reviews was often limited and it was not always possible to see how people's care had changed. For example, one person's care records indicated their mobility had changed and they now needed to use the stair lift for coming down stairs. A hand written note had been added to the risk assessment/care plan for this element and it was not clear whether a more detailed reassessment of the person's care needs around mobility had been undertaken. This meant it was not always clear people's care records contained up to date and appropriate information to allow staff to support people.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

We spoke with the acting manager about care records. She agreed the records were not wholly appropriate and showed us new care records she was hoping to introduce in the near future. She said she wanted to make the records more person centred and clear for staff to follow. The acting manager also told us she wanted to improve the quality of the daily records kept about people's care, to ensure they fully reflected what the person had achieved on each day.

Relatives we spoke with told us the home had been very responsive to their relation's needs. One relative told us that following a spell in hospital, their relative's need had changed considerably. They said the home had facilitated the person to move rooms, so they were on a lower floor and also were close to a bathroom and toilet. A relative we spoke with told us about their observations of another person living at the home. They remarked about how the staff had worked hard to support the individual and how they felt as a result the person's health and well-being had vastly improved.

People told us there were some activities at the home, although in the majority of cases people followed their own interests and hobbies. A number of people living at the home told us they enjoyed knitting. They told us they would buy wool from local charity shops and knit squares that were then made into blankets for local charities. Several people attended day centres. People told us they liked to go to local shops and often went to local coffee shops or local pubs for a drink and a meal. One person, who had a family background linked to horses, was supported to have a small daily bet on a horse race, by visiting the local bookmakers. People told us, and records confirmed people were also visited by relatives or went to visit them on a regular basis. We saw activities had been discussed at the most recent 'residents' meeting. People had suggested they would like to play games or be involved in a colouring club. We saw staff supported people to complete

adult colouring books on both days of the inspection.

People told us they were able to make choices. Several people had chosen to spend time in their rooms during the day, knitting, listening to music or watching television. On both days of the inspection staff advised us not to enter certain rooms as people had decided to have a 'lie-in' that morning. We saw staff supported people to make their own choices, such as a choice of meal, hot and cold drinks or by offering them a variety of yoghurt flavours after their tea. People's bedrooms, particularly those people who had individual rooms, were decorated in a way that suited their tastes, with posters, pictures and a number of soft toys. Staff told us a number of people enjoyed browsing local charity shops and purchasing small items. They said whilst they tried to direct people about their purchases, to prevent their room becoming over full, the ultimate decision lay with the person and, "They could spend their money as they wished." This meant the home supported people to make individual choices.

The acting manager and deputy manager told us there had been no formal complaints about the service within the previous 12 months. The acting manager showed us a copy of the home's easy read complaints document that was available to everyone who lived at the home. The document helped describe the sorts of things people may want to raise concerns about and how the problem may be dealt with. The acting manager told us she would be looking to review the document to ensure it remained accessible to people living at the home. One relative told us they had not made any formal complaints. They told us, "I have no complaints, but if I did and would raise them if necessary." Another relative said they had raised an issue when their relation first move to the home, but this was addressed and the issues had not re-occurred.

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager registered with the Commission. However, the acting manager, who had been at the home for around three weeks, told us the registered manager had left the home the previous week and she understood would be looking to cancel their registration in due course. The acting manager told us it was her intention to apply to become the registered manager for the service. The acting manager and deputy manager were present and assisted with the inspection on both the days we visited the home.

The acting manager was open and honest with us about the home and some of the shortfalls in the documentation. She immediately told us about the issues related to the storage and ordering of medication and explained how these were to be addressed. She also advised us policies and procedures at the home did not reflect current regulations. She said she was aware there was considerable work to be done to improve the service and she spent time explaining the changes she hoped to make in the coming months.

At the time of the inspection we found records were not always up to date, particularly regarding the management of medicines and the maintenance of care plans and care records. Whilst the previous registered manager had conducted monthly audits for December 2016 and January 2017, we found these did not always reflect what we found at the inspection. For example, the audit for January 2017, which the acting manager told us had been completed the previous week, did not reflect issues with water temperatures at the home. The audits for December 2016 stated there were no gaps in the MAR sheets, although we identified a number of issues in records from this period when we examined them.

The audits carried out at the home had failed to identify the window restrictors at the home did not to meet current guidance for care homes. There was no evidence accidents and incidents at the home had been reviewed to identify any trends or recurring themes.

We noted one person had been assessed for a DoLS and this had not been notified to the Commission, as providers are legally required to do so. The acting manager told us she would immediately rectify this.

We asked the acting manager and deputy manager if the provider undertook any formal audits when they attended the service. They told us the provider visited the home at least once a week to oversee the running of the home, but no formal reviews were undertaken. Staff we spoke with confirmed the provider regularly visited the home.

This meant there was a lack of robust monitoring and oversight of the home and the systems in place to deliver safe and effective care.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

The provider wrote to us following our inspection and told us the acting manager had now instigated a

robust audit process and was reviewing documentation to ensure it was appropriate and up to date. She also told us the acting manager would be conducting supervisions sessions with all staff and that policies and procedures at the home would also be reviewed.

Staff we spoke with were positive about the impact of the new manager. They told us they felt she was making appropriate and timely changes and they could already see improvements. Comments from staff included, "The new manager is already making changes. She is changing the way the work schedule is, which I think is for the better" and "(Acting manager) is really on the ball. We identified we did not have blue aprons for serving meals and she got some. All the care staff have aprons on now. She has made sure that things come into force."

We saw evidence a recent staff meeting had taken place. Minutes from this meeting showed a range of issues had been discussed including; the introduction of new staff rotas, the introduction of a communications book, a reminder about the safe handling of medicines and the importance of recording the outcomes when staff supported people to attend hospital appointments. Staff we spoke with told us they could raise issues themselves in these meetings, if they wished to do so.

Staff told us they enjoyed working at the home and there was a good staff team. They said they supported one another well. Comments included, "There is a good staff team and we get on well. Not all the time; but you can't always see eye to eye. But it's a good team workwise and we are all friends" and "It's a good team. We all try and do what we need to do to support each other."

The acting manager and deputy manager told us they were aware there was a great deal to do to improve the service, although they underlined the caring nature of the support people received. She told us she was aware there were a number of challenges ahead in taking the home forward and she had already had some discussions with the provider and felt she would be supportive of the planned changes.

Staff told us the home was linked closely with the local community. They said many of the people who lived at the home were well known to local shopkeepers or business owners. They said the businesses knew people and their particular likes and dislikes and supported them when out in the community.

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 10 HSCA RA Regulations 2014 Dignity and respect Systems were not in place to ensure people were treated with dignity and respect. Regulation 10 (1)(2)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure care and treatment was delivered in a safe manner because risks to people's health and safety had not been assessed and mitigated. Checks on the safety of the premises had not taken place, systems to prevent and control the spread of infection were not in place and medicines were not always managed safely and effectively. Regulation 12(1)(2)(a)(b)(d)(e)(g)(h)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to protect people from abuse or potential improper treatment. Regulation 13 (1)(2)(6)(c)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not established to ensure the

service operated effectively and in compliance with regulations. Monitoring and quality assurance systems were not robust and accurate, contemporaneous and complete records were not always maintained.
Regulation 17 (1)(2)(a)(b)(c)