Devaglade Limited

# Hazeldown Care Home

## Inspection report

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## Ratings

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| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

The inspection took place on 10 and 11 May 2017 and was unannounced on the first day but the manager knew we were coming back on the second day. The last inspection to this service was on the 1 October 2014 and the service was rated as good with no breaches. The registered manager at the time has since left and now provides some administrative support to the current manager.

The service is registered to provide residential accommodation for up to eighteen people with a recognised mental health need. The service is not fully occupied and had ten people using the service when we visited with one person in hospital.

There is a registered manager in post. 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 service was fully staffed and had the number of staff it said it needed. The staff employed were observed to be extremely caring and compassionate and worked hard to enhance the lives of people they were supporting. They gave up their free time to support people socially. We found there were insufficient staff to meet people's needs. Staffing levels had remained static for years despite an increase in people's needs. Staffing levels did not enable people to go out when they wanted when they needed support to do so. Most people did require support to go out because of the remote location of the service. The manager was on shift supporting staff and trying to oversee the overall management of the service and associated upkeep of records and auditing. They did not have a deputy to delegate things to. Care staff were providing care and support as well as doing domestic duties and cooking. This impacted on their ability to take people out according to their expressed needs and wishes.

People received their medicines as intended by staff who were suitably trained to administer medicines but staff would benefit from more specific guidance about the use and when to administer medicines as required. Medication profiles would also help to ensure staff received their medicines according to their preferences.

Risks to people's safety were mitigated as far as possible because staff were knowledgeable about people's needs and sought advice when needed. There were individual and generic risk assessments in place. Equipment was regularly checked to ensure it was safe to use. The environment was restrictive for people with physical disabilities due to steep stairs and internal steps.

Staff recruitment was adequate but there were no audits on staff files and there was no evidence of how the interview process was used to determine that staff had the right skills and attributes for the job. Staff felt well supported by the manager who was very knowledgeable and understanding. However formal mechanisms of support were limited. Staff had supervision but they were not regular and staff did not have

annual appraisals. Staff training and induction was good when first employed but there was limited evidence of opportunities for continued training and sharing positive practice. Most staff had higher qualifications and, or a care certificate.

People were encouraged to be involved in decision about their care. Everyone was deemed to have capacity. Staff were aware of the requirements of The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. When implemented correctly it ensures that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process.

Staff understood what constituted abuse and how they should respond to any allegations of abuse. However there had been a failure to notify CQC of different events affecting the well-being of people using the service and there was no provider oversight of this.

People were inadequately supported with their dietary needs. Staff involved people in menu planning and staff prepared meals with limited involvement from people. However we were concerned that although staff monitored people's weights and referred any concerns to the doctor there was little evidence that staff supported people to achieve sensible weight loss or promote healthy eating. A number of people had serious medical conditions and their records did not show us how staff were helping people in trying to mitigate the risks. There was also little information about promoting positive mental health and minimising people's anxiety. It was clear through our observations that staff were very attentive to people's needs and told us about things people had achieved but this was not reflected in people's care plans.

Staff were proactive in taking people to the GP and accessing other health care services. This helped ensure their health care needs were met.

Staff were supporting people to manage their own personal care and to contribute to the upkeep of the household. However no one was currently taking their own medicines and we could not see goals to help people become more self -sufficient. There was limited opportunity and social engagement for people outside the service.

Care plans documented people's needs and were based on an assessment of people's needs. Care plans were reviewed but did not record progress against goals. They also did not show clear actions in regards to incidents, change or unmet need and therefore were not sufficiently comprehensive.

There had been no complaints about the service and staff regularly asked people about how they were. There was limited family support so people relied on staff and, or advocates. The provider did not have an overarching quality assurance system and did not regularly seek people's views about the service. The manager did hold three monthly resident meetings and asked them to complete surveys annually about how they rated the service. Surveys were not used to gauge staff and professional opinion and we could not see how feedback was used to improve the service. People we spoke with were happy with all aspects of their care and did not raise any concerns.

There were no formal audits of quality and standard of care being provided in line with the services business plan and statement of purpose. We could not see how the provider was monitoring its own service to ensure people's needs were being met.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

This service was not always safe.

Staffing levels were not adequate to meet people's needs. Staff recruitment was not sufficiently robust.

Risks were mostly well managed but we could not always see what learning had taken place from adverse events and the manager was not notifying CQC of incidents.

Equipment was regularly serviced but the environment was restrictive and outdated.

Staff understood what constituted abuse and knew what actions they should take to protect people.

Staff were adequately trained and ensured people received their medicines as intended. More information about people's medicines and how and when they should take them would be helpful.

### Is the service effective?

**Requires Improvement**

This service was not always effective.

Staff received adequate training and support for their role. However there was a lack of structured supervision or appraisal of staff's performance. There were gaps in staff's knowledge in relation to the people they were supporting and their specific health care conditions.

Most people had capacity to make their own decisions and staff supported them with this and acted lawfully.

People were supported with their health care needs but there was concern about how people's physical and sometimes mental health needs were being met within the service particularly in relation to exercise and diet.

### Is the service caring?

**Good**

This service was caring.

Staff were knowledgeable, empathetic and caring.

Staff supported people in the way they wished to be supported but evidence of progress against goals was not always noted.

People were consulted about the service and made decisions about their care and the running of the service.

## Is the service responsive?

**Requires Improvement**

This service was not always responsive.

People did not have full access to the community at the time of their choosing because of the staffing levels.

People had an assessment of their needs and care plans put in place. These were reviewed but did not always show how staff were following the person's plan of care or highlight changes in people's needs.

The service had a complaints procedure and this was accessible. We could not see how the service made changes according to people's feedback.

## Is the service well-led?

**Requires Improvement**

This service was not always well led.

The manager was very knowledgeable, experienced, clearly motivated and supported staff.

They were proactive in supporting people and working in conjunction with other health care professionals to ensure people's needs were met.

There was no provider oversight or system of audit and review to ensure the service was run in the interests of people using it.

# Hazeldown Care Home

**Detailed findings**

## Background to this inspection

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

The inspection was carried out by one inspector over two days. The first day was on 10 May 2017 and was unannounced; the second day was 11 May and was announced. We were assisted by an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of mental health.

Before the inspection we looked at information we already held about this service including previous inspection reports and notifications which are important events the provider is required to tell us about. The service had completed a provider information return which gives information about the service and how they are meeting the regulations of the Health and Social Care Act 2008.

On the days of our inspection visit, we met with and spoke with seven people using the service, the manager, five care staff and one health care professional. We looked at three people's care and support plans and other records showing how the service was managed including staff records and medication records. We spent time at the service observing the care and support being provided to people and observing the interactions between people and the staff supporting them.

Requires Improvement

# Is the service safe?

## Our findings

On the day of our inspection the service had the number of staff the provider had calculated as being required. There were two staff members on duty and the registered manager. The registered manager was working alongside care staff to deliver care and had some time when not on a care shift to complete their management duties. They had part time administrative support, but no deputy manager. They told us they were also on call seven days a week and unable to delegate this to senior staff as there was minimum reimbursement for this. Their management role was compromised by working on shift and trying to manage the service effectively.

The rotas showed staffing numbers were reduced in the evening from 4pm to two and one member of staff at night with an additional member of staff sleeping in. This meant that people requiring additional support to go out and access community facilities could not always do this at the time of their choosing. The service was in a remote location with limited public transport. There was a car which could be used to transport people around. However, staff told us there must always be two staff at the service at any one time which meant people unable to go out by themselves, had to wait until staff were available to support them. .Staff told us people missed out on opportunities and staff often took people out in their own time. Care staff were also providing care and support and completing domestic duties and in the kitchen cooking.

The manager told us they did not have a dependency tool which they used to determine staffing levels based on people's assessed needs. This is important in determining how the service was meeting its statement of purpose which stated what they could provide and the range of needs they could meet. It was clear in discussions with staff that some people's needs had changed considerably. The manager was pro-active in flagging this up with social workers and getting people's needs reassessed. However this took some time and in the meantime, the current staffing levels were not adequate for people's needs as staffing levels had not changed or taken into account people coming in on short term stays. Staff confirmed staffing levels had always been the same so had not adapted to the needs of people using it. People had a wide range of needs, some complex and it was difficult to see how two staff would promote people's independence and we observed staff doing things for people rather than enabling them. People spoken with did not raise concerns about staffing but did about the lack of activity which was the impact of not having enough staff.

This is a Breach of Regulation 18. Staffing. Health and Social Care Act (Regulated Activities) Regulation 2014

People were supported by regular staff who worked as a team and helped make sure shifts were covered so people had continuity of support.

We spoke with people about their needs and if they felt safe in the service. One person told us "I feel reasonably safe here. You might get the odd less than stable type like I had a chap come into my room at night and he also bothered other residents but he's been removed from here now." Another said "I'm very safe staff are lovely, nothing is too much trouble for them." And another, "I feel safe here, they (staff) care for me, my key worker is very good to me."

The service had information for people and staff to follow in relation to safeguarding, complaints and advocacy. There was a clear safeguarding and whistle blowing policy which gave staff a list of contacts to call I they had any concerns. All staff felt confident in raising concerns. Staff confirmed they had received training and were able to recognise different types of abuse. We saw a Norfolk multi agency policy to support adults with additional needs which might make them more susceptible to harm and this was in people's care plans. This referred to the police regularly visiting the service to get to know and be able to support adults. However the manager told us this was not up to date and not current practice. It was therefore not relevant to keep this information in people's files. We viewed one safeguarding concern which had been reviewed and the safeguarding team felt the service had taken all the necessary actions. We could not see an incident where a person leaving the service when it would not have been safe for them to do so on their own, had been referred to the team

There were systems in place to help ensure people received their medicines as intended. Staff said people's medicines were stored in their own rooms in an appropriate, locked cabinet. Staff held the keys. No one took their own medicines but staff confirmed there were procedures in place to assess people to determine if they were able to take their own medicines safely. There were no gaps in people's medication records and there was a staff signature sheet so you could see who had administered the medication. This helped when auditing medication. Medicines were stored at correct temperatures to make sure they were safe to give to people and there was a check on this. The medicine record also showed that people's creams had been applied when required. There were protocols for prescribed when necessary medication. Where people required medicines as required to help manage anxiety, the guidance was not specific enough to help staff know when it would be appropriate to administer it.  This meant people might be administered medicines inappropriately.

We spoke with people about their medicines. One person said, "Yes I get my meds on time and a monthly injection." Another said, "I get my medication on time I'm treated very well."

We observed staff administering medication. They were knowledgeable and administered medicines safely and according to the services policy. Staff had training and there were detailed medicine competencies to ensure staff were able to administer medicines safely.  We saw a pharmaceutical audit completed in the last year and it did not identify any concerns about medicine practices. The service carried out monthly audits to help them assess if they were meeting regulation. We saw evidence that people's medical needs were reviewed which included a review of their medication.

Risks to people's safety were documented but specific incidents were not reported to CQC as required and there was no evidence of provider oversight. For example, we saw an incident in which a person left the service unnoticed and was found and brought back by police unharmed.  Incidents records did not state what actions were taken to reduce the likelihood of further incidents.  Peoples care plans detailed doors to be locked at night, alarmed and regular checks to take place but we did not know if this had been agreed with people or implemented as a result of the incident. Some people had signed to opt out of regularly night checks but we could not see if the risks of not doing so had been discussed. We also could not see if the safety measures in place had been put in place since the incident or if they were already in place, how did the person leave the service. We would expect to see this level of analysis.

People's records had an assessment of risk and showed that people had been given information and asked to sign it to show they had seen and understood the information such as the services fire procedures.

There were systems in place to ensure the environment and equipment was fit for purpose and equipment serviced regularly. There were individual and generic fire risk assessments stating what the risks were and

how these should be managed. There were records of checks of alarms, detectors and fire doors to make sure these were working properly. The service employed a maintenance person who had clear oversight of this. Regular fire evacuations had taken place to ensure people could safely be evacuated. We saw regular checks of water supplies and windows had restrictors on which were checked to ensure they were not broken.

Staff observed good infection control procedures and the service was visibly clean. However, staff were expected to clean the service and support people to keep the home clean. Some individual rooms had an odour but staff told us how they supported people with personal care, laundry and keeping their rooms tidy. People were prompted to go to the toilet when necessary. They did not always have time to do a deep clean and there were areas of the service which were superficially clean. Some areas needed refurbishment. The service itself was difficult to navigate and had a number of internal stairs and low ceilings which could cause injury. There were people at the service with visual impairment and mobility issues which were accommodated as staff used a mobile ramp so people could get about. Due to the number of vacant rooms, people with mobility issues could be accommodated in a ground floor room. However the stairs were narrow and steep and people had no other option in the first floor rooms but to use the stairs. People were observed coming down the stairs cautiously. There was no lift which meant careful consideration needed to be given to the suitability of the environment before admission. Other issues included rucked carpets which could potentially be a trip hazard. We did not see risk assessments for any of the above. The above needed to be taken into consideration when considering any new admissions.

The staff recruitment procedure was adequate but the manager was honest in saying they were permanently recruiting and found it difficult to get staff. This meant any applicant was usually employed unless they were clearly unsuitable. Staff had an interview but no records had been kept in review of this. Before employment, new staff were required to complete an application form and references were sought. Disclosure and barring checks were completed to ensure the staff was not banned from working in care or had a conviction which might make them unsuitable. Checks on the person's identify and current address was also on file.

Requires Improvement

# Is the service effective?

## Our findings

People's health care needs were monitored and met as far as reasonably possible. However we had concerns that people's dietary needs were not being adequately met by taking into account people's physical health needs. We saw some people on long term medicines to manage mental health symptoms had other physical issues including obesity and diabetes. Although staff tried to support people and referred people to the GP we could not see how staff were promoting healthy eating or lifestyles. There was little evidence that staff referred people to other agencies to help support them to make positive life style choices. One person had to be referred to the dietician via the GP who said they would review in a fortnight but there was no follow up information in the persons care plan so we could not see what advice was given or how staff used the advice to support the person differently.

The approach of staff was to give everyone the same quantity of food regardless of their needs or personal preference. This did not show an individualised approach to people's dietary needs and people were not given the opportunity to serve themselves. Menus were discussed with people and planned accordingly. The menus viewed for the week included puddings every day but did not include things like a fresh fruit salad which would have been a healthier option. A number of people had diabetes, unstable high blood sugars and either insulin dependent or moving towards this. Therefore low fat/sugar options would be more appropriate in those instances. Quite a few people using the service were clinically overweight and their care plans did not reflect how staff should support and encourage people with regards to nutrition and exercise. One person told us they had been told to reduce their sugar intake but at lunch, they were served a large portion of quiche, chips and beans and a pudding. They were not given an additional choice of something healthier or offered a smaller portion.

We noted one person's care plan stated they were at risk of dehydration and should be encouraged to drink. Staff told us no one was on a fluid chart so staff were not monitoring this person's fluid intake in any detail. The monthly review of their needs repeatedly indicated that the person was not drinking very much but did not show actions staff had taken to manage the risk or show any options considered.

Staff received adequate training for their role. Staff told us they were very conscious about keeping up to date with their training. Both staff members we spoke with had NVQ 3 and 2, one staff member pointed out that until they had been properly trained in the understanding and administration of medication, they were not allowed to give it. The provider owned other services and employed a training officer who would oversee staff training. Staff told us they did the care certificate which is a nationally recognised induction which provides staff with the knowledge they need and is based on competencies and skills. All staff went on to do additional vocational courses. However we found not all staff were sufficiently familiar with mental health issues or had received training in basic health care conditions i.e. epilepsy and there was not clear guidance for staff to follow. One person had issues with cognition and staff had not had any specific dementia training and there were no specific strategies to support this person so we could not see how their needs were planned for. We saw the training matrix which gave as an overview of training and when it required to be refreshed. Staff had received training in first aid but training had lapsed which posed a significant risk to people in the event of an emergency. However training had been booked. Other training was within date.

Staff felt supported by the manager and were having formal supervisions. However these were not planned regularly. There was no staff appraisal system which would support staff and document how they would be supported with their professional development. We saw minutes of staff meetings the last one being in April 2017. This meant they were not being held regularly and we could not see how staff were kept up to date with legislation and policy issue.

The manager and staff had a reasonable understanding of the Mental Capacity Act 2005 and the Deprivation of Liberties Safeguards. They told us no one was deprived of their liberty and there were no restrictions in place. We did see however the kitchen was locked at night and could not see a clear rationale for this although people did have access to drinks and snacks. Doors were also locked at night. One person had left the service in the early hours of the morning and was found walking round the village. The staff had been unaware of this and it was not clear from their documentation what steps had been taken to keep this person safe. Staffing levels in the service had not been reviewed in light of this incident.

People had assessments of capacity and no issues were identified. One person was described as having fluctuating capacity but it was not clear how this impacted on their ability to take decisions. It was recorded they could go to the shop themselves but this was no longer the case. This was also the person found by police walking around the village. People had signed consent forms giving staff permission to assist them with personal care and their medicines.

One person was suspected as having early on set dementia and this was being monitored. The person had a do not attempt resuscitation (DNAR) in place. This had been signed by the GP. However we noted the person had a next of kin and could not see the service had consulted with them so they were aware this was in place.

People we spoke with told us they had regular visits from outside professionals such as GP's Nurses, Opticians, and staff accompanied people for any outside appointments made with dentist, hospitals etc. And we saw evidence of this in people's care plans. One person said, "Since I have been here I have seen a chiropodist and an optician, I wasn't very well a little while ago with a chest infection they were very quick to get me to see my GP." Another said, "If I need the doctor a member of staff will always take me but once I was poorly here and they called the doctor out to see me quite quickly, I have also seen a dentist."

We noted where people were prone to constipation this was documented and we saw some interventions from the GP and community nurse but there was a lack of guidance to staff about promoting a healthy lifestyle through, diet, hydration and exercise.

One person had been at the service a long time and had a significant change in their needs. We saw they had the right equipment in place to manage them safely and the person usually required one staff member to assist but this was dependent on their fluctuating mobility. This was a concern because of the staffing levels. Staff had adapted the service to suit their needs and their needs were being reassessed.

One person was in hospital and was scheduled to come out the following day. However, staff told us the communication with the hospital had been poor because they were not next of kin and the person had no next of kin. Staff were not sure what the hospital had found or results of any tests of what changes to their care needs might be necessary. The service had not been to hospital to reassess and said the information would be on the hospital discharge letter. We could not be assured these were always sent back with people or would enable staff to plan accordingly to meet their needs. We learnt this person had a history of epilepsy and might have had a seizure but there was no clear evidence of this or how staff monitored this person throughout the day and night or if they had established any risks for this person.

Health action plans and referral letters were kept in the office. However, care plans were kept in the main building and were the main documents staff referred to. These documents did not include information for staff about how they should support people with long term conditions and this was an integral part of their support so would be beneficial to have this information in the main care plan. We saw regular blood checks for people with diabetes and taking warfarin.

Good

# Is the service caring?

## Our findings

We received very positive feedback about staff and observed staff who were relaxed and caring. They were attentive to people's needs. We observed one person who asked for almost constant attention. Staff were very patient in their approach and reassured them and made sure they had everything they needed. Staff were familiar with people's needs and spent short periods of time. They were respectful. For example a staff member asked a person 'can I sit with you and eat my lunch' to which the person replied, 'it's your home as well.'

We asked people about their home and how the staff promoted their independence. People told us they thought the staff were very kind towards them, and supported them to keep their independence by taking them out to do their own shopping. One person told us they liked musicals and they were going to the theatre with their key worker at the end of the week.

People's privacy and dignity were respected. We saw staff calling people by their name and conversing with them in a professional but affectionate way. People that were supported with personal hygiene confirmed that staff always knocked on their door before entering.

One person told us, "They are bright and cheerful not condescending in any way they always knock and ask to come in my room, I can wash myself but they always offer help. My key worker is a lovely girl she knows my likes and dislikes, at night we have a male and female carer but he is very respectful always knocks and gives me my medication."

Another person said "I'm comfortable and safe here they genuinely care about me. It was my birthday in April and they made a lovely fuss of me, I see my friends and sister every week there are no restrictions here, I can get up when I want, and go to bed when I want, we are encouraged to be independent by giving us the opportunity to clean our own rooms and wash our own clothes but they will do it for you if you don't want to do it."

We were told by one person and this was confirmed by staff, that the person had not accessed activities in a long time but since being here had grown in confidence and was taking small steps towards independence. They had done things which they had never done before. They were full of praise for the service and we saw them happy and relaxed. They said to us, "I feel very safe here I initially came for respite and didn't want to go back to live on my own. "They had begun taking pride in their appearance and we spoke with health care professionals who told us the circumstances some people had found themselves in had been far from ideal. They felt this service helped a lot of people progress and gave them a place of safety with an able staff team who helped people move forwards in their lives.

A few people said they felt lucky to be there and would not like to be anywhere else. Some people had limited contact with family and felt staff had become like family to them. Several people said they were supported to see friends. Another person told us staff took them to see a family member every week that they would not get to see otherwise.

People were consulted about all aspects of their care and support but a number of people said they were not aware of their care plan or involved in reviews. Evidence of reviews were seen but not all had been carried out recently.

Requires Improvement

# Is the service responsive?

## Our findings

Staff were not always responsive to people's needs but they worked hard to support people. The care was not personalised because there were insufficient staff to give people the one to one support they sometimes required. During the inspection, we observed that due to staffing levels people were not always supported to have one to one conversations, and there was limited opportunity for stimulating activities that people could participate in. A television was on all day with staff having little time to engage in anything other than a quick hello. The cook/carer went off duty and were replaced by another carer who proceeded to start cleaning toilets, bathrooms and communal areas. This member of staff told us "it is very frustrating but we all try to pull together for example I am on till 10 o'clock tonight then I do a sleeping night here, then get up tomorrow to start my shift again, we don't have a domestic so we all pull together for the cooking, cleaning and caring."

We asked people about how they spent their time and if there was enough to occupy them. We had observed people still in bed or getting up and going back to bed later. One person told us. "I go to church on Sundays. Someone will always go with me or my friends come for me and I see my sister but not much else to do really." Another said, "I have a hobby of word search I buy my own books; I go shopping sometimes with my key worker [staff member] looks after my money I just ask her for some, I have been here a long time they know me pretty well." Another said "I like to sit at the meetings and choose things to eat or I just walk about a lot." Another said every day I normally watch television or play a board game." Some people had high anxieties and although staff tried to offer support and reassurance it was not always possible for staff to spend a great deal of time with people to encourage and promote people's well-being.

We concluded with a higher concentration of staff employed, people would be able to participate in a wider range of activities and were currently largely dependent on staff to leave the village and had very few community facilities they could access independently. A number of people using the service would not be able to easily access public transport or travel by car which meant they were restricted in what they did. Staff told us that they did their best but were restricted in what they could offer.

We asked the staff what was organised on a regular basis for people. They told us one person went to work and there was an art class once week. Apart from that they said they tried to do things in the service in the evening such as games, sewing and keep fit. Staff said some people went on holiday but it tended to be the same people supported by staff. This is because of the individual levels of support people needed.

People were involved and consulted about the service. People felt they were treated as individuals and that staff had identified their personalities, likes, and dislikes and demonstrated this when engaging with them in small talk, and when helping with personal care. People felt their needs were met. One person said, "My key worker has been with me five months and knows me very well we really get on." Another person said "I can express anything here they listen to me I can come and go as I please I have never had to make a complaint."

We looked at three care plans. They were put in place following an assessment of the person's needs and

then identifying what support a person needed and what they could do for themselves. Each care plan was reviewed each month and we saw no changes or limited comments to show us what had been happening for the person that month. We discussed this with the manager and said what would have been helpful was a monthly summary documenting what had happened over the last month and any achievements, events or changes in need. People's daily notes also gave us very limited information about how staff were supporting people in line with their care plans.

People's care plans did not all include background for the person to help staff understand their current needs. We also noted they were not progressive. For example, staff told us about what people had achieved or new experiences people had but we could not see evidence of this in the care plan. Staff had recorded goals for people to achieve i.e. to independently bake a cake. However each month it stated this had not been achieved .We asked if no progress was being made towards the goal was it a goal the person wanted to work towards and why was no progress being made.

Some of the information in the care plan was not relevant or out of date such as the joint safeguarding protocols. We saw a mental capacity assessment dated 2013 and there had been clear changes to the person's cognition. Another person had a document stating they did not wish to be checked at night. This was dated 2014 and did not reflect the current situation. The manager confirmed this had been revisited but there was no evidence of this in the care plan. Other files were kept in the office which meant it was difficult to find the information required and there was no cross referencing.

Given that people's primary diagnosis was mental health there was very little guidance about supporting people with their mental health such as anxiety and depression. Other people also had the potential to self-harm or abuse alcohol and we could not see clear guidance for staff around this other than regular observations. In addition there was little evidence of how staff had or should support people with healthy eating and exercise which would improve their overall health.

There was a Breach of Regulation 9. Person centred care. Health and Social Care Act (Regulated Activities) Regulation 2014

The service had an effective complaints procedure and this was visible in the service. People knew how to make a complaint and said they would report any concerns to the manager if they were unhappy about anything. The manager told us they had not received any complaints and felt people were able to freely raise concerns. One person who may have found it difficult to raise a concern had an advocate in place to support them with this.

People felt they were involved in how the service was planned and run. The people we spoke with all felt they were encouraged to be independent and praised the staff and manager. A monthly meeting was held in the dining room for people to discuss menus and any other comments or suggestions they would like to make. The majority of the people we spoke with did not really understand what a care-plan was and could not remember seeing one.

Requires Improvement

# Is the service well-led?

## Our findings

The manager had been at the service for five years but had only been managing the service for about a year. They were extremely knowledgeable about people's needs and how to support people to ensure they got the right service. They had built up a good rapport with other professionals, staff using the service and people living in the service. They led by example and motivated staff. They were supportive of their staff and staff were of them.

Staff members told us they thought the manager was very good and very conscientious, very hardworking but did not have the support as there was no deputy manager which would have enabled the manager to take time off from being on call.

We found the manager was operating in isolation with little support in terms of their opportunity to meet other home managers to share ideas and get some morale support. They told us they had not received any support or supervision and there were no external audits of the service. The manager did say there was regular contact from a family member of the provider who they spoke with most days and found this helpful.

We noted the manager had failed to tell us about things occurring at the service which affected the health, safety and or well- being of people living there. We have asked the manager to supply additional information.

This is  a breach of Regulation 18. Notifications of incidents. Registration Requirements 2009. Health and Social Care Act (Regulated Activities) Regulation 2014

Equally there was no provider oversight of this. There were no audits of the care people received or things affecting their welfare and, or safety like accidents, incidents or falls.

The manager told us they were providing a service, supporting staff 24 hours a day seven days a week. The manager was updating policies and procedures and trying to keep up to date with legislative changes. They did not have sufficient support to do this.

They said staffing and budgets were a concern. The service was not and had never been full. Staff felt an updated website might help in terms of filling vacancies. The concern was the service openly admitted to not being able to recruit staff in such a rural location and most of the staff lived locally. The service relied heavily on permanent staff to cover the shifts.

Staff expressed their frustration of things they had asked for that were not met because of the financial constraints. We asked staff for an example of what they had asked for. One staff member said, "We have asked many times for the vehicle to be changed because one of our residents cannot fasten a seat belt round them restricting them from joining us on trips they have to take a separate taxi." Staff also said the communal car was becoming unreliable and was their lifeline.  Staff also mentioned the upkeep and

replacement of equipment and refurbishment. For example saying how long it took to replace the shower and walls needed painting and carpets replacing. The outside space was not arranged in a way in which people could sit outside and enjoy the views. Areas were concreted and there were no planters or flowers. The manager was not aware of a refurbishment, replacement budget and the service needed updating.

We saw a business plan which had not been updated for a number of years. This set out policy standards and risk management. It talked about regular staff meetings and staff appraisals. This was not happening in the service and it was not clear how the manager was being supported to do this as there was no provider oversight or monitoring of this service. It also spoke of monitoring the quality of life of people using the service. Systems to do this were poorly developed. It also said about having individualised care plans and setting goals to encourage and motivate people to take an interest in all aspects of their lives. There was poor evidence the service was doing this well. The service user guide which stated the aims and objectives of the service had recently been updated and stated people chaired their own meetings and took an active part in the home including interviewing for staff. There was no evidence these things were happening in practice. It also stated the home provided a comprehensive, activity/rehabilitation programme. Many people had been there for years and there was limited evidence of how people were supported with their goals and rehabilitation.

We found in reality, despite the excellent efforts of staff, people living at the service had limited opportunity for regular and fulfilling activities. People were not always adequately supported to be self-sufficient and have more control and autonomy over their lives. A number of people required a high level of interaction and input from staff which distracted away from people who required less support.

We found that staff were frustrated by the current situation and were trying their best to support people against the constraints on shift. People using the service had often come from more restrictive environments and therefore reported positive experiences of living here and the staff that supported them.

People were involved in decision making but in a limited way. No one we spoke with seemed to be aware of their care plans. The manager told us they sent out surveys annually for people to feedback their experiences and at other times they could share their views through their care reviews or as and when they needed to. The surveys did not go out to families, staff or professionals so were not very inclusive and no conclusions were drawn from the results of the surveys i.e. you said we did. We also noted some people had little contact with social workers and often people's needs were reviewed with little input from other professionals and, or families. This meant it was difficult to assess if the placement was meeting people's needs and if the service was progressive.

This is a breach of Regulation 17. Good governance. Health and Social Care Act (Regulated Activities) Regulation 2014

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider has not been notifying us of incidents which affected the safety and well-being of people using the service |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Care was not provided according to the needs of the individual. Neither did it sufficiently take into account people's personal preferences and routines. Insufficient staffing impacted on staffs ability to provide a personalised service. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have an overarching quality assurance system by which it judged the effectiveness of its service delivery and if it was achieving its stated aims and objectives.<br>17 1,2 (a ) (b) (e) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had not ensured there were enough staff at all times to meet people's individual needs and help them achieve their goals. |

They also did not ensure staff were adequately supported and had the training