Crossways Residential Home Limited

# Crossways Residential Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

The inspection took place on 23 and 24 August 2016 and was unannounced. Since our last inspection, the provider of this service has changed. This was the first inspection under the new ownership of the service.

Crossways Residential Home provides accommodation and personal care for up to 23 older people. At the time of the inspection there were 20 people living at the service, many of whom were living with dementia. A registered manager was 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.

People were not protected from potential harm due to ineffective risk management processes. The risks to people were not effectively identified and managed by staff members. People were not supported by sufficient numbers of staff to meet their needs. The registered manager was aware of the requirements of safe recruitment practices. People received medicines that needed to be taken on a regular basis as prescribed. Where people needed medicines on an 'as required' basis their needs had not been identified and therefore staff could not be certain these were given as prescribed. People were supported by a staff and management team who could describe signs of abuse and knew how to report concerns. However, staff had failed to recognise when poor care practices may be considered potential abuse and put people at risk of harm.

People's rights were not protected where they were unable to consent to their own care and treatment. Decisions were not made on people's behalf in line with the Mental Capacity Act 2005. People were being deprived of their liberty without the correct legal applications having been made and without less restrictive options being considered. Staff did not always have the knowledge and skills to support people effectively. People's dietary needs had not always been correctly identified and understood by staff. People's day to day health needs were met through regular access to healthcare professionals.

People's dignity was not always upheld and promoted by care staff and their independence was not always promoted. People were supported to make some choices about their care and people felt staff were caring towards them.

People's needs were not always met by the care they received. Care plans did not outline people's needs and preferences or the care being delivered. People did not always have sufficient access to leisure opportunities and meaningful activities. Complaints recorded were responded to appropriately by the registered manager.

People were not protected by quality assurance systems that ensured all issues within the service were identified and the required improvements made. People had involvement in the service through meetings and surveys. People were supported by a staff team who felt supported by managers but not always fully

involved in the staff team or development of the service.

The provider was not meeting the requirements of the law regarding safe care and treatment, staffing levels, consent, dignity and respect, person centred care 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## 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.

People were not always protected from harm due to ineffective risk management systems. People's 'as required' medicines were not always managed effectively. People were not protected by sufficient numbers of staff to meet their needs.

People were supported by a staff team who could recognise signs of potential abuse and knew how to report concerns. However, staff had failed to recognise poor care practice that could cause risk of harm to people.

### Is the service effective?

**Inadequate**

The service was not consistently effective.

People were not protected by a staff team with the knowledge and skills to support them safely and effectively.People's rights were not always protected by the effective use of the Mental Capacity Act when decisions were made about their care.

People's nutritional needs were not always identified and known to staff. People were supported to access healthcare professionals when required.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People's dignity and independence was not always upheld and promoted.

People were supported to make some choices about the care they received. People felt staff were caring towards them.

### Is the service responsive?

**Inadequate**

The service was not consistently responsive.

People's care and support did not always meet their needs and

preferences. Care plans did not always reflect these needs and preferences or the care being delivered to people. People had limited access to activities and leisure opportunities.

Complaints recorded had been responded to, however, not all issues had been recorded.

## Is the service well-led?

**Inadequate**

The service was not consistently well-led.

People were not protected from the risk of harm due to ineffective quality assurance systems. Quality assurance systems did not ensure that all issues within the service were identified and the required improvements made.

People had involvement in the service through meetings and surveys. People were supported by a staff team who felt supported by managers but not always fully involved in the staff team or development of the service.

# Crossways Residential 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 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 23 and 24 August 2016 and was unannounced. The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with three people who lived at the service and three visitors who were friends or relatives. Many people living at the service were living with dementia and were not able to talk with us about their views around their care. To help us understand the experiences of people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service.

We spoke with the registered manager, the deputy manager, the provider and five members of staff including a kitchen assistant and care staff. We reviewed records relating to people's medicines, five people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance. We carried out observations across the service regarding the quality of care people received.

Inadequate

# Is the service safe?

## Our findings

People were not protected by the effective management of risks to their safety. Risks to people were not effectively identified and minimised. We saw risk assessments for several people living with diabetes that contradicted their care plans. For example, some documents outlined sugar should not be consumed and others outlined the same people took sugar. Some assessments and care plans outlined regular blood sugar testing was completed for certain individuals, however, staff confirmed this was not done and they did not feel it was required. They were not able to confirm if a medical professional had advised blood sugar testing was not required. Staff members we spoke with were not able to clearly and consistently outline the needs of people with diabetes, including both care staff and kitchen staff. Not all care staff we spoke with were able to identify the symptoms which would indicate people's blood sugar levels presented a risk to their health. One staff member said, "I honestly don't know!" and confirmed they needed training in this area. We saw one person being lifted from a chair under their arms by a staff member and a 'volunteer'. This volunteer was working on a placement from a local school. Moving people in this way can increase the risk of injury including skin tears and dislocation of their shoulder. The registered manager confirmed the staff member had recently completed training in moving and handling and the volunteer was not trained and should not have been assisting people to move. Risk assessments did not fully outline how to move the person safely and were not reflective of staff practice in the service.

We looked at how the registered manager managed accidents and incidents that arose in the service. We saw accidents were recorded, however, they were not always thoroughly investigated and risk assessments were not reviewed and updated as a result of any 'lessons learned'. For example, we saw one person had recently had a fall within the service causing injury. The person's risk assessments had not been reviewed following this fall, this resulted in no changes to reduce the risk of further falls were considered or put in place. The management of accidents and incidents did not always reduce the risk of further injury to people.

We were told by staff and management how techniques were being used to restrain people. Staff members told us people could, when anxious, hit out at staff when they tried to provide their personal care. They told us they were using restraint to enable personal care to be completed. We asked staff if they had received training in techniques to restrain people safely and they told us they had not. The training records provided by the registered manager confirmed staff had not received appropriate training. One staff member, when asked how to keep a person safe while restraining them said, "I haven't been told to do anything". They told us they used their own methods which seemed appropriate to them at the time. We identified an accident that had arisen prior to the inspection resulting in a skin tear to a person's arm when staff held them to guide them from a room. We confirmed with the registered manager that the member of staff had not explored any methods of guiding the person without contact before deciding to hold their arm. We asked staff how they tried to manage behaviour before restraining people and found staff did not understand how to effectively identify and reduce the triggers of people's behaviour. We looked at care plans to identify what instructions were given to staff on how to manage behaviour before restraint was used. We saw the analysis of people's behaviours was not effective in identifying any potential 'triggers'. Identifying triggers can assist in care being delivered in a way that may reduce the likelihood of behaviours that challenge staff from arising. People were identified as being 'aggressive' without consideration as to why people became anxious

and presented behaviours that challenged staff. People were not kept safe from the risk of harm or injury through effective management of behaviours that may challenge.

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

Most people were not able to share their views with us about staffing levels within the service. Visitors told us they felt more staff were needed. One visitor said, "More than anything else they need more staff". Another visitor told us, "They don't have enough staff. Definitely not". Staff members we spoke with also told us they felt there should be more staff. One staff member told us, "All it takes is for one to be doubly incontinent and it's all over". Staff we spoke with confirmed a fifth of the people living at the service required two staff members to support them to move with a hoist. This could at times result in no other staff members being available to support other people in the service. In addition, it was confirmed by management and staff there was currently no laundry assistant employed resulting in staff involvement in tasks other than that of supporting people with care.

We saw there were not always sufficient numbers of staff available to support people during the inspection. One staff member administering medicines was required to frequently stop the medicines round to provide support to people due to no other staff being available. This resulted on the first day of inspection in people's medicines administration being delayed. We observed several instances where people were without staff members to support them for extended periods of time. During these time periods we observed people struggling to eat without support and saw one instance of two people assisting each other to reposition a walking frame to help someone move as staff were not available. We saw the staffing tool used by the registered manager to calculate the required numbers of staff did not accurately reflect the dependency and needs of people living at the service. People were not supported by sufficient numbers of staff to meet their needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

We looked at how the registered manager ensured staff members were recruited in a way that ensured they were suitable for their role. We saw a range of pre employment checks were completed for staff members before their start date including reference checks and Disclosure and Barring Service checks (DBS). DBS checks are completed to ensure employers are aware of any potential concerns about a staff member's criminal history. Staff members were recruited safely into the positions they were recruited for.

We saw medicines were stored securely and were locked in a secure medicines room. Staff members we spoke with understood the correct temperatures medicines should be stored at and took steps to address concerns when they arose. We saw some good practice around medicines administration for people who received regular prescribed medicines and found these were given as prescribed. We did identify concerns around medicines needed by people on an 'as required' basis. Staff were not aware which medicines should be given on an 'as required' basis. There were not sufficient guidelines available to staff to assist them in understanding when people may need these medicines. This had resulted in some people being given 'as required' medicines on a regular basis when they may not have been needed. Staff members did not have a good knowledge of how to manage these 'as required' medicines. The staff and management team were not able to confirm everyone had received their 'as required' medicines in line with their individual needs. The management team advised they would review their practices to make improvements immediately.

People told us they felt safe living at the service. Visitors also told us their friends and relatives were safe and

protected from potential abuse. Staff we spoke with were able to describe the signs of potential abuse and how they would report any concerns. The deputy manager and registered manager could demonstrate where some concerns about people had been raised appropriate action had been taken. We saw these concerns had been reported to the local safeguarding authority and actions were in place to protect people from any potential harm. We did however identify practices during the inspection that had not been identified by staff members as causing potential harm to people. For example, not moving people in a safe way and not managing behaviours that could challenge effectively.

Inadequate

# Is the service effective?

## Our findings

Most people were not able to share their views about staff member's skills and experience due to their capacity. Staff members told us they felt some staff didn't have the required skills and training to work effectively with people. We identified several areas in which sufficient training was not being provided through observing staff working in the service and reviewing training records provided by management. We found staff did not sufficient knowledge around how to support people with dementia effectively and inclusively. We found staff were using restraint to assist them in providing personal care to people. Staff did not have the knowledge and skills to keep people safe and they had not received training in how to restrain people safely. We saw training had not been provided to any staff in diabetes care and this was an area we also found staff did not have the knowledge and skills to support people effectively. Staff knowledge and around the Mental Capacity Act 2005 (MCA) was not sufficient and resulted in people's rights not being upheld. We also found that the knowledge of management was not sufficient in various areas. For example, the Area Manager had created a policy around the management of challenging behaviour which referred to the types of 'aggression' people may demonstrate, some of the language used described people as 'predatory'. This demonstrated a lack of understand around the management of challenging behaviour how how people should be supported and referred to in a respectful and dignified manner. People were not always supported by a staff team who had the required skills, knowledge and training to support them safely and effectively.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who had the capacity to provide consent to their own care were enabled to do so. Staff we spoke with could describe how they would seek consent from people prior to providing care and support to them. 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. We saw where people did not have the capacity to consent to their care and make their own decisions, the principles of the Act were not followed.

We saw some capacity assessments were present in people's care plans, however, these were not unique to people's individual needs. Some of these capacity assessments were not related to specific decisions about people's care as defined by the Act. For example, one assessment concluded the person was 'allowed' to 'make some decisions but not major ones'. Appropriate representatives (for example relatives) were not involved in these capacity assessments as also outlined by the Act. We saw decisions were being made on people's behalf who did not have the capacity to make their own choices or provent consent to their care. The principles of the MCA were not being followed in order to make these decisions. We saw people were being restrained without staff and management exploring options that were less restrictive before considering this practice. We saw staff were administering medicine covertly to one person. This person's capacity had not been assessed and the decision had not been made in their best interests in line with the

MCA. The knowledge of staff and management around the principles of the MCA were not sufficient. The registered manager confirmed they did not feel their knowledge around the MCA was sufficient and provided assurances they would seek further training as a matter of urgency. People's rights were not protected due to the ineffective application of the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent

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 saw various examples of people being deprived of their liberty without the relevant applications having been submitted to the local authority. People were not able to leave the service when they expressed a wish to do so. We also found that least restrictive options were not being considered prior to people being deprived of their liberty. For example, one person was being restrained during personal care as they often refused and displayed behaviours that challenged. We were told by staff and the registered manager about reasons this person may have a fear of water. However, this information had not been used to explore alternative methods to complete personal care before using restraint techniques. An application had not been submitted to the local authority to obtain the consent required by law for this person to be cared for in this way. People's rights were not protected through the effective application of DoLS.

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

People gave us mixed views around the food and drink they received. One person said, "The food is not bad. We get a choice and they know what I like. They know I don't like beans so they give me spaghetti instead". Another person told us, "I don't like it, but I just try to eat it". We saw people's care plans did not always effectively identify their dietary needs and staff knowledge around people's needs was not adequate. For example, we identified people who had high cholesterol and diabetes and their dietary needs had not been identified and understood by staff. Dietary sheets held by kitchen staff were not accurate and therefore people's needs were not understood by those responsible for preparing food. We asked one member of staff working in the kitchen how food was adapted for those living with diabetes and they were not able to outline how this was done. The first day of our inspection was a hot day and people were seen to be asking staff for drinks. We saw drinks had not been made readily available to people and we spoke with the deputy manager who provided assurances this would be addressed. We saw drinks were made more readily available on the second day of our inspection. Visitors confirmed that drinks were not always made available for people. A visitor told us how they had asked for a glass of water for one person and, "I see they still haven't done it". People did not always receive the support they needed to meet their nutrition and hydration needs.

People told us they get access to medical professionals in order to support their day to day health needs. Visitors also confirmed they felt people had access to healthcare professionals. One visitors told us, "If they need to call the doctor, they call him immediately." We saw from people's care records that regular contact was made with professionals such as doctors, nurses and chiropodists. As people's needs around their diabetes had not been effectively identified, we were not able to confirm if these people received appropriate healthcare support. People did however receive regular contact with certain healthcare professionals.

Requires Improvement

# Is the service caring?

## Our findings

People were not able to share their views with us about how staff protected their privacy and dignity. We observed the care people received to help us understand people's experiences. Visitors told us care staff did protect people's dignity. One visitor told us, "If they need to change [my relative's] clothes downstairs they will take her to another room. Or if its in the bedroom they will ask me to wait outside". Staff we spoke with were able to describe how they would promote people's dignity while supporting them with personal care. However, we saw people were not always supported in a way that promoted their dignity. We saw examples of people sitting in dirty clothing and with clothes protectors on after meal times for an extended period of time. We saw one person sitting in the lounge with wet trousers after being incontinent. We saw a further example of a person being hoisted in a communal area in a way that lifted their clothing. Their dignity was not protected and we saw staff further compromised their dignity by not restricting the number of staff and people watching. We saw multiple staff members, including domestic staff and a volunteer watching in addition to the other people present. One person was observed saying, "There's a crowd of onlookers!" Staff did not take steps to protect this person's dignity while they were transferred in the hoist. We saw people were referred to in an undignified way in care plans and policies, for example people were outlined as being 'aggressive'. We were provided by management with a policy around the management of challenging behaviour that described people as being 'predatory'. This demonstrated to us that the management team were not instilling a culture that promoted the dignity of people in the service. People were not supported in a way that protected and promoted their privacy and dignity.

This is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations Dignity and Respect.

Staff we spoke with could describe how they promoted independence when providing personal care by encouraging people to do as much for themselves as they can. We saw that people were not always encouraged to be as independent as possible in all aspects of their care. For example, we saw people struggling to eat independently, without provision of adaptive cutlery or plates to support them. We saw the environment was also not supportive to people living with dementia and was not reflective of current guidance of how to promote independence. For example, many people were in need of staff to support them to mobilise around the home. There was no signage available on many doors and rooms within the service to help people orientate themselves without support. We spoke with the registered manager, deputy and provider who advised they would review ways to promote people's independence further. People were not promoted to be as independent as possible in their environment.

People told us they thought care staff were caring towards them. One person told us, "I am very well looked after. Staff are fantastic they look after me very well". Visitors also confirmed they felt care staff were caring. One visitor said, "They are marvellous". Staff told us they tried to be caring towards people. One member of staff told us, "It's more like a home than a care home", "It's like you're looking after family". Another member of staff said, "I think this could be my Mom. How would I like my Mom to be treated". We saw caring actions such as the provider's newsletter being translated into one person's first language. We found care staff had good intentions and wanted to provide good care to people. However, we found care staff did not always

recognise when care was not dignified and caring.

We found people were involved in choices about their care. Staff tried to involve people in decisions about their care, for example the food they chose to eat. The provider and deputy manager told us how they had experienced problems with the lift in the service and therefore had fitted a stair lift. This was to ensure people continued to have choice about where they spent their time while the lift was out of service. People were supported to make some choices about their care.

Inadequate

# Is the service responsive?

## Our findings

Most people we spoke with were unaware of their care plan or did not have the capacity to be involved in this aspect of their care. People's care needs were not always effectively identified and therefore staff and managers could not confirm that all people living at the service received the support they needed. We saw care plans did not always outline people's needs and this impacted on the care that was received. We identified several instances where restraint was being used without people's needs being fully considered. For example, one person with a fear of water was being restrained in order for personal care to be completed. Staff and management had not considered the impact of this phobia on their support needs. They had not considered alternative ways to meet this persons' needs before using restraint. We saw on the first day of the inspection all of the men living at the service were unshaven. Staff we spoke with confirmed this was not a preference but that only one staff member within the service was able to shave people. We were told people would refuse a shave from other staff members. When this member of staff was working on the second day of the inspection the men had received a shave. Staff and management we spoke with had not identified people's preferences around shaving and had not considered the cause of people refusing shaves from other staff members. This staff member was due to leave the provider's employment and no consideration had been made to how men's preferences around shaving would be identified and how their needs would be met after this time. We also identified further issues with care delivered and care plans meeting people's needs. For example, we found issues with the identification of people's dietary needs. Staff were not able to outline people's needs consistently and care plans contained various instructions that contradicted the actions staff should take.

Where people did not have capacity to be involved in their care we did not see sufficient consistent involvement of an appropriate representative. For example, a relative who knew and understood their needs and preferences well. We saw monthly reviews were completed by key workers that did not involve the person or their relative. We also saw assessments completed under the Mental Capacity Act 2005 (MCA) did not involve appropriate representatives. The reviews that were completed of care plans did not identify issues within the care plans or effectively identify people's needs. People and their representatives were not sufficiently involved in reviewing their care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care.

Most people were not able to share their views about the activities within the service and their access to leisure opportunities. A visitor told us they felt entertainment could be improved. Some staff members told us about personal interests they had identified with people and how they supported this. For example, reading religious passages, playing music and singing. Staff told us that the staffing levels impacted on their ability to complete activities with people and we saw this reflected in our observations during the inspection. We saw that minimal interaction took place between staff and people living at the service and most people were not engaged in any form of activity for extended periods of time. Minimal work had been done to identify people's personal interests and to support them to complete activities while living with dementia at the service. We spoke to the provider about the lack of meaningful activities at the service and

they told us they would review how this is approached by staff and managers in order to make improvements.

Most people were not able to share their views about the complaints process in the service. However, one person when discussing complaints told us, "I would talk to the manager but sometimes [name] promises [they] will do something but then forgets to do it". We saw no complaints from people living at the service or their relatives had been recorded for nearly 10 months. We were told by the deputy manager this was due to no formal complaints having been received in this time. We identified through speaking with the management team that concerns had been raised by people and relatives about the lift breaking down and laundry items going missing. Steps had been taken to resolve these concerns with the lift being repaired during the inspection and a new system for labelling laundry had been introduced, however, these concerns had not been recorded. We spoke to the management team about recording complaints to ensure all actions could be identified to make the required improvements in the service provided to people.

Inadequate

# Is the service well-led?

## Our findings

The provider had failed to ensure that the staff and management team had sufficient knowledge and skills to manage risks within the service, to provide care in a way that met people's individual needs and kept them safe. We found care practices that put people at risk of harm; for example staff were using restraint without having received appropriate training. People's needs had not been fully assessed to ensure that the care being delivered was appropriate to meet their needs and reduced the risk of harm to them. The provider and registered manager were not aware that the care being delivered put people at risk of harm and mistreatment. They had failed to recognise the culture in the service supported poor care practice and did not promote dignity and positive dementia care.

We looked at how the registered manager and provider completed quality assurance checks in order to identify issues within the service and make any required improvements. We saw numerous checks had been completed on the building and environment and a programme of improvements in this area were underway. We did however, identify that audits and quality checks around the quality of care provided to people were limited and issues within the service had not been identified. We saw despite regular checks being completed on care plans, these checks were not effective and had not identified basic concerns such as contradictory information and guidelines for staff about how to keep people safe. We saw some documents were not used effectively, for example fluid charts were completed retrospectively and not when people were given drinks. We found numerous issues in the recording on these documents that had not been identified through the registered manager's own quality checks. We saw accident audits did not capture all accidents recorded and did not identify any trends or 'lessons learned' in order to reduce the risk of further incidents within the service. As a result not all incidents had been fully investigated and actions were not put in place to reduce the risk of further harm to people. For example, one accident not recorded involved a skin tear due to a member of care staff holding someone's arm to encourage them to move. The registered manager confirmed the accident had not been fully investigated and actions to reduce further risk had not been considered. The registered manager and provider were not aware of the issues we identified during our inspection. This showed there were insufficient or ineffective quality assurance checks completed throughout the service.

We found a range of policies and procedures were in place. Some of these policies and procedures did not reflect current legislation and guidelines and some were not fully embedded and implemented across the service. For example, we saw the medicines policy outlined covert medicines could be administered with the permission of a doctor and the person's family. This practice was embedded in the service and resulted in covert medicines being administered without the principles of the Mental Capacity Act 2005 having been followed. We saw the diabetes policy outlined that nobody living at the service with diabetes was to be given sugar without considering people's individual needs or capacity to make choices. The policy was not followed by staff as we found examples of people with diabetes being given sugar in their food and drink. The registered manager and provider had failed to ensure that people were protected by effective policies and procedures that were understood and implemented by staff.

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

governance.

People told us they knew who the management team were. They told us the registered manager and deputy manager were friendly and approachable. A visitor told us, "The manager is very good. [Name's] always there to shake your hand and say hello. They always keep you informed of what's happening". Another visitor told us, "I would say it's reasonably well managed. The manager is fairly reliable". Visitors told us they felt involved in the service but mentioned that they did not always feel the registered manager acted on comments raised. One visitor told us, "Sometimes things aren't acted on, or forgotten". We saw people and visitors had been involved in residents and staff meetings where people's choices and preferences were discussed. We saw some limited examples of how people's views were used to make changes to the service. For example, through discussions about the menu and identifying one person may like crochet. We discussed with this with the provider who advised they would review how further improvements can be made to involving people in the development of the service.

Staff told us they felt the management team were supportive. One staff member told us, "Management have been really supportive". Another told us, "[The deputy manager] is really good. She's brilliant. She's really supportive." Staff told us they felt more work needed to be done to get the whole staff group working effectively as a team. They told us they felt involved by managers in meetings that took place. However, we were told that sometimes they felt their ideas and suggestions weren't acted upon. One staff member told us, "Managers listen and take it on board but nothing changes". People were supported by a staff team who felt supported but felt further improvements were required to staff involvement and teamwork within the service.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive care that met their needs. Care plans did not reflect people's needs and preferences. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People's dignity was not promoted by staff members through the care and support provided. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>People's rights were not protected due to the ineffective application of the Mental Capacity Act 2005. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were not protected from potential harm due to ineffective risk management processes within the service. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 13 HSCA RA Regulations 2014 |

| | |
|---|---|
| personal care | Safeguarding service users from abuse and improper treatment<br><br>People were being deprived of their liberty without the required legal applications (DoLS) being made and without less restrictions options having been fully considered. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>People were not protected by quality assurance and governance systems that identified the issues in the service and the areas of improvement required. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>People were not protected by sufficient numbers of staff to meet their needs. Staff did not have the appropriate training to meet people's care needs safely and effectively. |