The Island Residential Home

The Island Residential Home

Inspection report

114 Leysdown Road, Leysdown on Sea,
Isle of Sheppey, Kent, ME12 4LH
Tel: 01795 510271
Website: www.islandresidentialhome.com

Date of inspection visit: 10 February 2015
Date of publication: 22/05/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection was carried out on the 10 February 2015 and it was unannounced.

The Island Residential Home is a privately owned care home that provides accommodation and personal care for up to 44 people. There were 31 people living at the home on the day of our inspection. Some were older people living with dementia, some had mobility difficulties, sensory impairments and some were younger adults. Accommodation is arranged over two floors. There is a passenger lift for access between floors.

The Island Residential Home has a registered manager. 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 and associated Regulations about how the service is run.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into force on 1 April 2015. They replaced the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

People felt safe in the home and their needs were met. All the relatives we spoke with felt that their family members were safe. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

The safeguarding policy was not up to date and did not give staff adequate guidance. However, staff knew to report safeguarding concerns to their manager and the local authority.

There were risk assessments in place for people. The assessment identified the risk or potential harm to the person or to staff, the actions to be taken and by whom. The risk assessments did not have a specified date for review and had not been updated when people's needs changed.

The home had not been suitably maintained and effective systems were not in place to identify hazards and ensure action was taken to protect people from harm. Although maintenance contracts were in place; suitable action had not been taken to address risk when there were faults.

The provider and registered manager did not have a tool or system to assess the level of staffing in relation to people's needs. There were sufficient numbers of staff working at the home, but they had to complete household tasks which had a negative impact on the time they were able to spend with the people at the home.

Effective recruitment procedures were not in place to ensure that potential staff employed were of good character and had the skills and experience needed to carry out their roles.

Medicines were not always stored, administered and recorded safely. Medical advice had not always been followed. Medicines that were classed as controlled drugs (CD's) under the Misuse of Drugs Act 1971 had not always been recorded appropriately.

Medicines competency checks were carried out when staff had completed medicines training. However, there were no records of these checks. We made a recommendation about this.

People's nutrition and hydration needs were not always met.

Staff told us that if a person had been recommended to have a pureed diet, then all the components of the meal would be pureed together. This meant the person would not know what they were eating the person's choice was restricted.

Care was not consistently planned to meet people's assessed needs. Assessment and care plans lacked information to support staff to provide safe, consistently or in a person centred manner. Personal histories had not been included in people's care plans to support this approach.

There were limited planned activities within the home which would provide stimulation and interest.

The complaints procedure did not evidence the provider's responsibility to investigate complaints and did not detail who people should talk to if they were not happy with the complaint response. We made a recommendation about this.

People had completed surveys in September 2014. Concerns raised within the surveys had not always been responded to in a timely manner.

There was no evidence to support an audit framework at the home. Health and safety audits that had been undertaken by the provider were not robust. Policies and procedures were out of date and not fit for purpose.

Staff had received training relevant to their roles and were well supported by the registered manager. Staff communicated effectively with people and demonstrated that they would only support people when they had gained their consent and according to their wishes and choices.

The staff were knowledgeable about the principles of the Mental Capacity Act (MCA) 2005. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the MCA Code of Practice. The managers understood when an application should be made and they were aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Summary of findings

We observed people eating their meals in the dining rooms. Some people chose to eat with other people and others chose to eat alone. Staff served the food and helped people if they needed support.

Staff were kind, caring and patient in their approach and had a good rapport with people. They gave people plenty of time to communicate their needs. Staff demonstrated respect for people's dignity. They were discreet in their conversations with one another and with people who were in communal areas of the home. People's information was treated confidentially.

People were supported to maintain their independence. We saw that people were encouraged to do things for themselves.

People and their relatives were confident to raise problems with the registered manager if they needed to. Relatives had completed surveys and the results were positive.

The home had a calm and relaxed atmosphere. The calls bells were answered quickly. Staff demonstrated that they understood and promoted the home's values.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 protected from the risk of abuse.

Risk assessments had not been updated when people's needs changed.

The home had not been suitably maintained. Effective systems were not in place to identify hazards and ensure action was taken to protect people from harm.

Effective recruitment procedures were not always in place. There was not always enough staff on duty to meet people's needs.

Medicines were not always stored, administered and recorded safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

People did not always receive adequate nutrition and hydration to meet their needs.

Staff received training relevant to their roles and were well supported by the registered manager.

Staff communicated effectively with people.

People were supported to access appropriate healthcare advice from health professionals as required.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff were kind, caring and patient in their approach. They gave people plenty of time to communicate their needs. However, staff spent time carrying out other duties which restricted the time they spent with people.

Staff demonstrated respect for people's privacy and dignity.

People were supported to maintain their independence.

People's information was treated confidentially. Personal records were stored securely.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care was not consistently planned to meet people's assessed needs. Assessment and care plans lacked information to support staff to provide safe and consistent care.

Summary of findings

People did not have sufficient activities to keep them stimulated as there were limited planned activities.

People and their relatives were confident to raise problems with the registered manager if they needed to.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

The complaints procedure did not evidence the provider's responsibility to investigate complaints and did not detail who people should talk to if they were not happy with the complaint response.

There was no audit framework at the home. Policies and procedures were out of date and not fit for purpose.

Staff demonstrated that they understood and promoted the homes values.

The Island 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 10 February 2015 and was unannounced. The inspection team consisted of two inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications we had received. A notification is information about important events which the home is required to send us by law.

During the inspection, we spoke with seven staff, including the registered manager, 16 people and six relatives. We also spoke with the provider. Some people were unable to tell us about their experiences, so we observed care and support in communal areas. We looked at five people's care records, five people's medication records and looked through management records, including training records and six staff files.

We gained feedback about the service from health and social care professionals.

We asked the provider and registered manager to send us information after the inspection. We asked for the home's fire risk assessment to be sent. This was received within the timescales that had been set and agreed.

Inadequate

Is the service safe?

Our findings

All the people we spoke with said they felt safe in the home. One person said, "Safe as such'. Another person told us, "I never gave it [safety] a thought". Another person told us, "Oh yes, without a doubt. I feel more safe in my room here than I did at home". One person told us, "I know that I'm safe".

All the relatives we spoke with felt that their family members were safe. One relative said their family member was, "Absolutely safe". Another relative told us, "She [their family member] wanted to be safe and now I know she is". Another relative said, "I can sleep at night, knowing she's safe and cared for". One relative explained that their family member had been involved in an altercation with another person. The relative informed us that the home dealt with the incident well. Although people and their relatives felt the service was safe we found that the systems, the premises and staffing did not keep people safe from the risks of harm.

The Island Residential Home had a safeguarding policy. The policy had not been reviewed or updated since 2010, however the provider and registered manager explained that they had purchased a new set of policies and these were going to be collected the day after our inspection. This home's policy detailed what staff should do if they suspected abuse. The policy listed the possible signs and symptoms of abuse. It did not detail the names and numbers of organisations that abuse should be reported to. The home had a copy of the local authority 'multiagency safeguarding vulnerable adult's policy, protocols and guidance'. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. The staff knew who they would contact if they had safeguarding concerns. They said they would initially raise the issue with the manager. They were also aware they could report safeguarding incidents to the local authority's safeguarding team. People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify and prevent possible abuse from happening.

There were risk assessments in place for people, which included infection control, nutrition, moving and handling and skin integrity. The assessment identified the risk or potential harm to the person or to staff, the actions to be taken and by whom. The risk assessments viewed did not have a specified date for review and had not been updated when people's needs changed. For example, people's falls assessments had not always been reviewed following a fall to identify new or increased risks to the person. This meant that care provided did not always take into account people's changing needs.

Moving and handling assessments had been completed but lacked detail. These did not provide staff with the information and guidance about the techniques required to support people to move and transfer safely. For example, 'sitting to standing – one carer'. Staff were not provided with details of the equipment and techniques to be used when supporting people in different situations to ensure that they are moved safely each time.

This failure to fully assess people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had not been suitably maintained. For example, some windows did not fit the frames which meant the rooms were cold. We found one window on the first floor that did not have a window restrictor fitted. The fire exit route from the upper floor to the rear of the building had not been maintained appropriately and led out to an area which had trip hazards such as weeds and garden debris. The concrete in the garden was at different levels and had not been clearly marked. Many rooms within the home had ramps to overcome differences in floor height. One person said, "I can manage the ramp but I hate the thing, especially the one downstairs which is more like a mountain. My frame runs away". These issues posed a risk of falling for people as they moved around. One nurse assessor told us, "Although the general building inside is looking tired; when I visit, it is always clean and tidy".

Although maintenance contracts were in place; suitable action had not been taken to address risk when there were faults. We found that the fire equipment service had been carried out on 30 January 2015, this had identified that two detectors were not working at the front of the building. Although parts had been ordered, a risk assessment had not been carried out to mitigate the risks of not having working smoke alarms. An environmental risk assessment had not been completed and risks to people and staff associated with the building had not been identified. Risks

Is the service safe?

associated with Legionella and Legionnaires' disease had not been assessed and monitored. There were no systems in place to ensure that repairs and maintenance was carried out in a timely manner. For example, repairs had been recorded in the handyperson's repair book in August 2014 had not been completed, such as leaking waste pipe to a toilet and broken tiles in the shower room. Effective systems were not in place to identify hazards and ensure action was taken to protect people from harm.

The lift had developed a fault the week before we inspected, this had not been repaired. This restricted people's freedom to move around the home and meant that people living upstairs that moved around using a wheelchair were unable to access the community.

This failure to maintain the premises was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 this corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and registered manager told us that the home did not have a tool or system to assess the level of staffing in relation to people's needs. There were sufficient numbers of staff working at the home, but they had to complete household tasks which had a negative impact on the time they were able to spend with the people. One staff member told us "There would be enough time for caring if we didn't have to do extra tasks or escorts". 'Escorts' means that staff escort and accompany people to appointments outside the home which leaves fewer staff available to care for other people. Staff had to complete laundry, cleaning and cooking tasks alongside their care and support roles. Staff treated people with kindness and respect, but did not always have the time to complete some tasks. For example, we observed a person being left in their wheelchair after lunch for around thirty minutes as the staff member could not get help from other staff members to use the equipment to assist this person to move. This meant that staff did not always have the time to adequately support people and meet their needs fully or to their satisfaction.

This failure to ensure that there were sufficient numbers of staff to safeguard the health, safety and welfare of people was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a recruitment and selection policy. It stated that 'During interviews we maintain careful notes in order that we demonstrate any decisions'. The policy failed to detail actions which should be undertaken when criminal records checks identified convictions. We found that interview notes consisted of tick boxes. Gaps in employment had not been explored and documented during interview had not been completed. Therefore a full employment history was not available for all staff employed by the service. There was no recent photograph as part of their proof of identify for staff members on their recruitment file. There was no evidence to show that three staff members had been appropriately checked for their suitability to work with people. The provider did not have a robust process for recruiting new staff to the home which placed people at risk of potential harm.

This failure to operate effective recruitment procedures to ensure that persons employed are of good character and have the skills and experience needed to carry out their roles was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were inconsistencies in the way medicines were stored and administered. For example, we saw that a bag containing prescribed medicine was left on an open shelf outside the locked medication room, in an area accessed by people and visitors to the home. Supplement drinks prescribed for one person at the home were used for three other people. We reviewed the care plans of the three people, and noted that they had been referred to the dietician who had recommended the use of supplement drinks, but no specific detail regarding the amount and frequency of the drinks was recorded. These people's medicine administration charts (MAR) contained hand-written and unsigned entries for the supplement drinks. One person's GP had recommended that their prescribed pain medication had been increased to better manage the person's pain. The person's MAR chart showed that they not been given two doses of the medication. This meant that the person's pain was not being managed according to medical advice.

The fridge in the medications room had not been checked consistently. The home's policy stated that the temperature should be checked daily, however, the temperature had been checked on two occasions in a ten day period. Medicines that were classed as controlled drugs (CD's)

Inadequate

Is the service safe?

under the Misuse of Drugs Act 1971 had not always been recorded appropriately. For example, the stock records of CD's had been recorded on loose leaf paper rather than bound records. There was no evidence of audits of medicines records, storage, stock numbers, stock rotation and disposal.

One person's care plan stated that the person could self-medicate. There was no evidence of a risk assessment to determine any risks or hazards posed by self-medication. Staff told us that the person did not have a MAR chart, and that their medication was sent from the pharmacy in a pre-filled and labelled 'Dossett' box. Staff gave the person the 'Dossett' box to allow them to self-medicate, and then stored the box in the locked medication after each medication round. There were inconsistencies in the recording of care given, including whether or not the person had received their 'Dossett' box that day. Staff did not know about the side effects or common reactions to the medications in the 'Dossett' box. This meant that staff would not be assured of when the person had taken their medication, or what to do if the person had an adverse reaction to the medications.

This failure to ensure that medicines were suitably stored, administered and recorded was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

People who could tell us about the staff said that staff knew what they were doing. One person said, "The staff are brilliant" and then they explained that a new member of staff was recently introduced to them and then helped them to get washed and into bed. They explained that the manager observed the staff member and said that afterwards the manager "Asked for my opinion on how the new carer had got on, and what I thought of her. I was pleased about this". One person told us "The owners have been helping us today. They are very helpful". Another person told us that staff supported them with their personal care. They said, "You ask them to do it and they do it. But not to take your independence away. That's good". A relative told us, "I'd give them a gold star. They have some challenging people there and they cope well".

Staff had undertaken training relevant to their roles. The training records evidenced that staff had undertaken training which consisted of completing workbooks. For example, 33 out of 38 staff had completed safeguarding adults training. The five remaining staff had been given their workbooks for completion. The home employed a training coordinator who ran regular training workshops. The training coordinator explained that as well as completion of workbooks some training was carried out as a practical assessment, for example, moving and handling training. Additional training was resourced and booked when required. The training coordinator told us staff who had completed medicines management this was followed by a competency assessment. This was then signed off before staff were allowed to administer medicines unsupervised. However, despite these checks being unannounced and verbal feedback being given there were no records of these checks having taken place or that staff were competent and confident to administer medicines in a safe and effective manner.

We recommend that medicines competency checks are appropriately documented and ensure staff are following the guidance available to them.

The home had an induction plan which new staff were supported to achieve. The training coordinator supported staff to work through their induction which included meeting people who live in the home, supporting people at lunch time, reading policies and procedures and getting to know the building. Staff were well supported by the registered manager with a supervision schedule in place to ensure that staff received six supervisions per year. Staff meetings were held frequently. The registered manager provided the support and supervision required to support staff in their roles.

Staff communicated effectively with people. One staff member explained that if people were unable to communicate verbally they could help them to make choices by showing them two sets of clothes. They said people could either point to the item of clothing or look at the one they wanted.

Staff had received training in the Mental Capacity Act (MCA) 2005. The MCA aims to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Staff knowledge of the principles of the act was good. Staff demonstrated that they would only support people when they had gained their consent and according to their wishes and choices. The staff understood that people should be supported to make day to day decisions and that if they were assessed as not having the capacity to make a decision, a best interest meeting should be held involving people who know the person well and other professionals, where relevant.

The provider information return (PIR) showed that one Deprivation of Liberty Safeguards (DoLS) application had been approved by the local authority. The registered manager knew that other people in the home required a DoLS application as people were restricted from leaving the home and were provided constant supervision and care for their own safety. They were working with a care manager from the local authority regarding one application. The DoLS had been reviewed to ensure this person was not subject to unnecessary restriction and met with legal requirements. The manager and staff were aware of their responsibilities under the Mental Capacity Act 2005(MCA) and DoLS.

People's views and comments about the food varied. One person said, "I'm veggie. They do try. I eat all right"'. One person said, "Excellent food, ample food. A lovely cook. They get to know my likes". Another person told us that the food was good and, "You can have what you like for breakfast". On person told us that the food "Varies, like anywhere. I go off food sometimes. They know exactly how to do my toast". Another person told us the food was, "Reasonable, with plenty of vegetables". Relatives said, "I

Requires improvement

Is the service effective?

think the food is ok. It's well cooked canteen food, not a la carte"; "We have been concerned that some meals are not suitable for her [their family member] one teatime she had thick sliced bread and chunks of cheese. Not good, as she has no teeth". Another said, "We think there's quite a range of food and she can have sherry". Another said, "If they know he likes something, they try to give him more".

There was limited menu choice available at the home. We observed a person asking the chef what was for lunch, and the chef responded with one option. We observed the lunch meal and saw that people were served the main meal, and were offered an alternative only if they objected. We spoke with the chef, and saw that there was a list of people's dislikes in the kitchen. Staff told us that when the amount of food available for a meal looked insufficient, then smaller portions would be given out. People were not always supported to be able to eat and drink sufficient amounts to meet their needs.

We noted that one person had been recommended to have monthly weight checks, but the person's care plan demonstrated that there were gaps in the weights recorded. There had been a significant weight loss over a two month period, but the care plan was not amended to reflect this. There was evidence that people had been referred to the dietician for further nutritional support, but recommendations were not always carried out. For example, the dietician recommended that one person's supplement drink was changed to another one to improve weight gain, but staff continued to give the person the previous drink. This meant the person didn't receive the recommended care that met their needs.

Staff told us that if a person had been recommended to have a pureed diet, then all the components of the meal would be pureed together. This meant the person would not know what they were eating with each mouthful, and meant that the person's choice was restricted.

This failure to ensure there was there was enough food, choice and suitability of food was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At lunchtime, we observed that people ate their meals in the dining rooms. Some people chose to eat with other people and others chose to eat alone. Staff served the food and helped people to eat if they needed support. The dining area had a relaxed atmosphere, the radio was playing and staff were talking with people. Some people told us that that didn't get enough to drink and they felt thirsty. One person told us that drinks were only given at certain times. However, we saw staff giving out drinks and encouraging people to drink.

People's healthcare needs were met. People explained that when they had fallen or when they had become ill, staff had supported them to see the GP or attend the hospital. One person explained that they had a series of falls, the registered manager had ensured that they went to the GP and their medicines had been reviewed. The person told us, "I've not fallen anymore". Care records evidenced that people had seen their GP, district nurses and had received urgent medical assistance when they needed it.

Requires improvement

Is the service caring?

Our findings

People we spoke with had good things to say about the staff. One person said all of the staff were, "All caring here". Another said, "A lovely home with lovely staff". One person told us, "They've been very kind and helped me a lot". One person who found it difficult to communicate verbally smiled when we asked if the staff were caring. One person told us, "They accept me here, all the staff are really nice, they look after me well and were great on my birthday, everyone joined in". Another person said, "They are great here. I've no worries about that. They treat me like family. They know about everything that's happened to me and it's fine".

Relatives told us they were happy with the care provided. One relative said, "My mother is not an easy person and they treat her with dignity". Another relative said, "We watch the staff, how well they treat them all. They do forget things, but I don't mind. Because we feel she is loved here". One relative told us, "My mum is happy though, and staff are good at supporting her". Other relatives said staff were "Helpful", "Understanding", "Happy and pleasant". All of the relatives said they were able to visit when they wished. One relative added, "They make us welcome".

A nurse assessor told us that staff and management were always friendly, approachable and appeared to go the extra mile to support people. For example, they told us that staff had worked on their days off to help out, and had provided extra support to people who needed it.

Staff were kind, caring and patient in their approach and had a good rapport with people. They gave people plenty of time to communicate their needs. They did not rush and stopped to chat with people, listening, answering questions and showing interest in what they were saying. We observed staff initiating conversations with people in a friendly, sociable manner and not just in relation to what they had to do for them. Staff showed they really knew the people that lived in the home. We saw and heard light hearted chatter between people and staff responded well to people. Although we observed positive work, staff spent time carrying out other duties which restricted the time they spent with people. This meant there was not a consistent caring approach and the amount of meaningful time spent with people was restricted.

Staff demonstrated respect for people's dignity. They were discreet in their conversations with one another and with people who were in communal areas of the home. Staff were careful to protect people's privacy and dignity and people told us they were treated with dignity and respect. For example, staff made sure that doors were closed when personal care was given. One staff member told us, "It's a privilege to care for these people, I don't treat people how I want to be treated as we are all individual, and so I treat people how they want to be treated".

Staff told us how they supported people to maintain their independence. We saw that people were encouraged to do things for themselves. For example, one person was able to eat their lunch independently until they were too tired to carry on picking up the cutlery. Staff then discreetly supported the person to eat.

People's information was treated confidentially. Personal records were stored securely. People's individual care records were stored in lockable offices to make sure they were accessible to staff. Staff had a good understanding of how to protect people's confidentiality. For example, one staff member told us that information could only be shared with people who need to know such as GP's.

People told us that they were able to leave the home when they wished. They gave us examples of going to the shops, the betting shop, restaurants and going out for a walk. People that needed support from staff to go out in the community also had the opportunity to do so. For example, a small group of people went out during our inspection with a member of staff to get their shopping. One local authority care manager told us that the person they worked with who lived at the home went out two to three times per week.

One person told us that their spiritual needs were met because a priest visits the home, the person added that they would like the priest to visit more often.

Requires improvement

Is the service responsive?

Our findings

People told us that their needs were met. People were supported to bath and shower according to their preferences. However, one person said, "I have a bath with the hoist. There are dedicated days for a bath. I like a shower, but I can't get in the cubicle". A person that was supported to move using a hoist was very happy with her care. They told us, "They do it well, very reassuring" and "I get help when I need it". Although people generally had a positive view of their care needs being met effectively we found that improvements were needed.

All the care plans contained assessments for various activities, for example, helping people to use the toilet, dressing and personal care. However, we noted that more information was required in the assessments and care plans to support staff to provide safe and consistent care. For example, one person had a cognitive assessment which acknowledged the person's confusion and memory impairment, but no further mental capacity assessment or best interest meeting had taken place. This meant that care was not consistently planned to meet people's assessed needs.

In another care plan a person displayed behaviour that other people may find challenging. Staff told us of one incident between the person and another person at the home, but there were no completed incident forms about this in the person's care file. There was no process for de-escalation of challenging or aggressive behaviour. This meant that staff did not have the required knowledge to suitably support this person or how to defuse the situation before it occurred.

Despite there being a policy in place with regards to life history, the care plans did not evidence people's personal histories. This meant that new staff may not have all of the information needed to support people in a person centred manner. Care plans did not evidence how people had been involved in planning their own care. Staff had reviewed the care plans regularly. If there were changes required these were noted on the 'care plan adjustments' sheet, however these changes were not always added into the care plan. For example, one person care plan adjustment recorded that the person required support at mealtimes, however this was not added the care plan to provide guidance to staff.

There were limited planned activities within the home. The home's website advertised that there were three planned activities a week 'Shopping trips', 'Resident meeting' and 'Bingo'. Staff confirmed that the planned activities on a Monday each week were "Reminiscing and games" and on a Friday there was bingo. The provider was looking to recruit an activities coordinator so that activities could take place on Tuesday, Wednesday and Thursday each week to give people more stimulation and increase activities. One person said, "Sometimes there are things to do but not very often. I'd like more". Another person told us, "I normally watch quizzes on TV". People told us that they enjoyed bingo.

The failure to adequately assess and plan care to meet people's needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that a few people attended an external day care centre on a weekly basis, this meant that some people were involved in their local community.

People and relatives were clear about how to complain if they needed to. The complaints and compliments procedure was available in the reception area. The complaints procedure did not evidence the provider's responsibility to investigate complaints and did not detail who people should talk to if they were not happy with the complaint response, which should include the Local Government Ombudsman. The policy told people they should complain to the Care Quality Commission (CQC), this was not correct. CQC do not investigate or manage individual complaints. People who we spoke with told us that they would not be afraid to raise a problem with the manager.

We recommend that the complaints procedure is reviewed and updated to ensure that people and their relatives have clear guidance.

The Island Residential home had received compliments from individuals and organisations that were involved in people's lives. For example, one read 'Thank you most sincerely for the care received by [person] in his final years

Requires improvement

Is the service responsive?

at The Island Residential Home'. Another compliment stated, 'Thank you for taking care of my aunt and for all the care that you gave her towards the end of her stay on this earth'.

One person told us that the registered manager would help them. One person told us, "I don't have problems" and another person said that they would talk, "Either to the carers, the manager, or the owner" if they had a problem.

Relatives were confident to raise problems with the registered manager if they needed to. They told us they were happy with the outcome of any concerns raised. One relative said, "There were some minor problems but they've looked at what we've said and worked it out, It's all fine". Another relative told us they were concerned about the sandwiches. They said, "I see the carer on duty. One, especially, has a good relationship with my mum, and it's sorted". Another relative said, "We'd go to them if a problem, but there's none". Another relative told us, "No cause to complain ever, but we know what to do".

Relatives had been sent surveys in August 2014 to gain feedback about the home. The registered manager told us that all survey results were discussed with staff and if issues are raised they would meet with people. The survey responses had been positive. Some relatives had made additional comments. One friend of a person living at the home had said, 'My friend has never been so happy, moving him to the home was the best thing in his life for many years. It is so good to see him smiling again, the staff and home are wonderful'.

People had completed surveys in September 2014; staff had helped people to complete the survey. Surveys had not always been responded to. For example, three completed surveys showed that people didn't know how to complain. One person who had been asked 'Do staff listen and act on what you say?' had responded with 'Staff need to make more time'. Another person had staff support to reply to the same question, the completed survey said 'Is unhappy on how staff talk and treat her, wishes it was better'. The registered manager was unaware of the comments within the surveys and had not followed these up to address them. This meant that people's concerns had not been responded to in a timely manner.

This failure to act on feedback was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

People gave us positive feedback about the registered manager and the provider, we observed that both the registered manager and the provider knew people and stopped to talk. One person, told us, “It’s not home, but it is good”.

Relatives also gave positive comments about the registered manager and provider. All the relatives we spoke with knew them. One relative told us they had, “A good relationship with them both. They are good people. They call if something is wrong, but can be slow to let me know about hospital appointments”. Another relative said, “We pop in to see the manager and owner. We’ve never had anything to worry about”. Another relative said “We are not the greatest family at communication ourselves, and they have to manage us, I wouldn’t say a word against them. I couldn’t ask for more”. One relative told us that the home kept in touch with them. Another relative explained that one of the home’s greatest strengths was, “The staff have been there long-term”.

Health and social care professionals told us the home was very proactive and contacted them regularly if there were any concerns. One professional said, “I am very happy with the service we receive from the staff and management at The Island Residential Home and will be happy to use the care home in the future”.

The home’s website stated, ‘Our aim is to offer our residents the opportunity to enhance their quality of life by providing a safe, manageable and comfortable environment. In addition, support and simulation are given to help maximize residents' physical, intellectual, emotional and social capacity. In order to achieve our aim we recognise the following as basic values that contribute to the quality of life for our residents’. The values were listed as ‘Privacy, Dignity, Independence, Choice, Rights and Fulfilment’. Staff demonstrated that they understood and promoted these values, however the aims to provide a safe and comfortable environment had not met by the provider because we found breaches of regulations relating to premises, medicines and staffing.

Communication was generally good within the home. The registered manager identified that communication could be better as staff had delayed to report equipment that wasn’t working correctly. For example, the overhead hoist in one of the bathrooms was not working correctly. Staff were not using the hoist and were supporting people to use other bathrooms. However the hoist defect had not been reported to the manager.

The registered manager worked weekends on a regular basis; this meant that they were kept up to date with what was happening in the home. We spoke with the registered manager about their roles, responsibilities, challenges, risks and achievements. They explained that there had been some challenges in the previous few months due to concerns that had been raised about the service. However, they worked with the provider and the local authority and other agencies to improve practice. The registered manager explained that they received support from the staff team. They described the team as “Outstanding”. The stated there were many improvements still to make but they were confident that the provider would support them with the process. However, we found the registered manager and the provider were not effectively checking the care and service and using these checks to drive improvements. The improvements were being made in response to outside agency’s informing them of what needed to be done. The registered manager had not identified all of the shortfalls we found.

The provider’s quality management policy stated there were ‘Formal annual audits’ and performance would be monitored on a day to day basis. The policy did not state what the formal audits consisted of. There was no evidence to support an audit framework at the home. The care plans and MAR charts were not routinely checked, and there was no evidence of any other regular checks to monitor the quality of the care provided. Health and safety audits that had been undertaken by the provider were not robust. For example, monthly room audits had last taken place in September 2014. The audits did not evidence that all areas of the home had been checked; the audits had only looked at people’s bedrooms and some communal rooms and had not checked all rooms within the home.

There were no systems in place to check that repairs and maintenance had been carried out in a timely manner. The provider set out a monthly maintenance list and assigned tasks for the handypersons. However, the provider had not checked that items added to previous lists had been completed. The maintenance list dated February 2015 had failed to identify premises defects which we found during the inspection.

Requires improvement

Is the service well-led?

Policies and procedures were out of date and not fit for purpose. The policies and procedures had all been purchased off the shelf and not individualised to the home. For example, the home had a policy on restraint. The registered manager told us that the home does not restrain people. However, the policy stated that staff could restrain as a last resort. The provider had made arrangements to implement a new policies and procedures system.

This failure to regularly assess and monitor the quality of the service was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence to show that the home had been visited by the local council on the 27 January 2015. A list of recommendations had been produced and the provider had started to work through these.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 People who use services and others were not protected against the risks associated with unsafe or unsuitable care and treatment because of inadequate assessment, Care did not always meet their needs. Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services and others were not protected against the risks of inadequate nutrition and dehydration because people lacked choice. Regulation 14 (1) (2) (a) (i) (ii) (b) (3) (a) (b) (4) (a) (b) (c) (d) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Failure to ensure that there were sufficient numbers of staff to safeguard the health, safety and welfare of people. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).

The enforcement action we took:
We served the provider a warning notice and asked them to comply by the 31 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with the unsafe use and management of medicines because medicines had not been stored, administered or recorded appropriately. Regulation 13.

The enforcement action we took:
We served the provider a warning notice and asked them to comply by the 31 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Effective recruitment procedures were not in place to ensure that persons employed are of good character and have the skills and experience needed to carry out their roles. Regulation 21 (a) (i) (b).

The enforcement action we took:
We served the provider a warning notice and asked them to comply by the 31 March 2015.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

People who use services and others were not protected against the risks of inappropriate or unsafe care because the quality of the service had not been regularly assessed and monitored.

Regulation 10 (1) (a) (b) (2) (b) (I).

The enforcement action we took:
We served the provider a warning notice and asked them to comply by the 31 March 2015.