C & K Healthcare Limited

Honister

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was undertaken on 13 August 2018 and was unannounced. This inspection was undertaken in response to concerns the Care Quality Commission (CQC) had received from local authority monitoring and commissioning teams.

At our previous inspection of this service undertaken in March 2016 we found the service was meeting the required standards under the previous provider. This was the first inspection under the new registration with the new provider, C & K Healthcare Limited. At this inspection we found that there were serious failings from the provider and management to ensure people received care and support in a safe and effective way.

Honister is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Honister is a care home without nursing registered to provide accommodation and personal care in one adapted building for up to 19 older people some of who may live with dementia. At the time of the inspection there were 19 people living there.

The service had a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider had not supported the newly appointed registered manager with mentoring or supervision in their new role. The registered manager did not have any autonomy to manage the service in the best interests of the people who used it which had a negative impact on safety and people's dignity.

The provider had failed to support or encourage staff to undertake the training they needed in order to care for people safely. The management team did not have protected management time to undertake routine safety audits. Quality monitoring was inconsistent, had not identified risks to people and had not served to mitigate risk to people`s health and wellbeing. The provider had failed to undertake quality checks of the service to satisfy themselves that the service they provided was safe, effective, caring responsive and well-led.

The provider did not have a clear overview of the service provided or actions that were necessary to improve the quality of the service. The provider had failed to act on advice given by external health and social care professionals. Relatives of people who used the service knew the registered manager by name and felt that they were approachable with any problems.

Accidents or incidents were not always managed robustly and not always used as learning to improve the

safety of the service. Risk assessments were not always detailed and did not clearly describe the controls in place to help mitigate risks to people's safety and well-being. The environment was not always appropriate to promote people's safety. The staff team was not sufficiently knowledgeable to promote people's safety in the event of a fire. People were supported to take their medicines by trained staff however, we found some shortfalls which meant we could not be confident that medicines had always been administered in line with prescriber's instructions.

Some of the staff team demonstrated a lack of understanding of infection control matters and some areas of the home required more in depth cleaning. We received mixed feedback about the staffing levels in the home. People told us that they felt safe living at Honister and relatives had no concerns about people's safety at the home. Staff had been trained in how to safeguard people from avoidable harm and were knowledgeable about the potential risks and signs of abuse. Safe and effective recruitment practices were followed to help make sure that all staff were of good character and suitable for the roles they performed at the service.

Staff had not always received training, subsequent refresher training and supervision to support them to be able to care for people safely. We received mixed feedback about the support provided for the team and not all staff told us they were confident to go to the management for support.

The environment in the home was bland and was not enabling for people who may live with dementia or sensory impairments. People were provided with a good choice of food and they were supported to choose where they wanted to eat their meals. People's day to day health needs were met in a timely way and they had access to health care and social care professionals when necessary.

People's records were not always maintained in a manner that promoted confidentiality. Aspects of the maintenance of the environment did not promote people's dignity. There was a lack of storage for people's incontinence items which meant their rooms were cluttered with these items. Some aspects of record keeping did not promote people's dignity. People's relatives told us they were happy with the staff that provided people's care and staff members said that they believed people received a good standard of care. Staff had developed positive and caring relationships with people they clearly knew well.

People's care plans were not sufficiently detailed to be able to guide staff to provide their individual care needs or end of life wishes. People's relatives said they had not been involved in developing people's care plans even where people did not have the capacity to make their needs and wishes known themselves. There were no activities taking place at the home during the course of the inspection.

There were regular meetings scheduled for people who used the service and their relatives to share their opinions about the service and facilities provided at Honister however, these meetings were not well attended. The provider had a complaint policy and procedure however, just one complaint had been received this year. There was no system in place to capture verbal dissatisfaction of people who used the service and visitors to the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Accidents and incidents were not always managed robustly and not always used as learning to improve the safety of the service.

Risk assessments were not always detailed and did not clearly describe the controls in place to help mitigate risks to people's safety and well-being.

The staff team was not sufficiently knowledgeable to promote people's safety in the event of a fire.

People were supported to take their medicines by trained staff.

Staff did not always demonstrate an understanding of infection control matters.

People felt safe living at Honister and relatives had no concerns about people's safety at the home.

Staff had been trained in how to safeguard people from avoidable harm and were knowledgeable about the potential risks and signs of abuse.

Safe and effective recruitment practices were followed to help make sure that all staff were of good character and suitable for the roles they performed at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People received their care and support from a staff team who had not always received training, subsequent refresher training and supervision to support them to be able to care for people safely.

Not all staff were confident of management for support.

The environment in the home was bland and was not enabling for people who may live with dementia or sensory impairments.

People were provided with a good choice of food and they were supported to choose where they wanted to eat their meals.

People's day to day health needs were met in a timely way and they had access to health care and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

People's records were not always maintained in a manner that promoted confidentiality.

The maintenance of the environment did not promote people's dignity.

A lack of storage for incontinence products meant that people's rooms were cluttered with these items.

Some aspects of record keeping did not promote people's dignity.

People's relatives told us they were happy with the staff that provided people's care.

Staff had developed positive and caring relationships with people they clearly knew well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not sufficiently detailed to be able to guide staff to provide their individual care needs or end of life wishes.

People or their relatives had not been involved in developing or reviewing care plans to ensure they accurately reflected people's care needs.

People did not have access to day to day activities or opportunities for engagement.

The provider had a complaints policy and procedure in place.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not supported the newly appointed registered manager with mentoring or supervision in their new role.

The registered manager did not have any autonomy to manage the service in the best interests of the people who used it.

The provider had failed to support or encourage staff to undertake the training they needed in order to care for people safely.

Quality monitoring was inconsistent, had not identified risks to people and had not served to mitigate risk to people`s health and wellbeing.

The provider had failed to undertake quality checks of the service to satisfy themselves that the service they provided was safe, effective, caring responsive and well-led.

The provider did not have a clear overview of the service provided or actions that were necessary to improve the quality of the service.

The provider had failed to act on advice given by external health and social care professionals.

Relatives of people who used the service knew the registered manager by name and felt that they were approachable with any problems.

Honister

Detailed findings

Background to this inspection

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

The inspection was prompted in part by concerns raised with the local authority in regards to the staffing levels at the home and the management of risks to people's health safety and wellbeing. This inspection examined those risks.

This inspection took place on 13 August 2018 and was unannounced. The inspection was undertaken by one inspector.

Before our inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us. We had not requested a provider information return (PIR) to be submitted to us at this time. This is information that the provider is required to send to us, which gives us some key information about the service and tells us what the service does well and any improvements they plan to make.

As part of the inspection we observed staff support people who used the service, we spoke with three people who used the service, seven staff members, representatives of the senior management team and the registered manager. Subsequent to the inspection site visit we spoke with relatives of four people who used the service to obtain their feedback on how the service was run.

We received feedback from representatives of the local authority health and community services. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records relating to two people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Requires Improvement

Is the service safe?

Our findings

When accidents or incidents occurred in the home, such as people experiencing trips and falls, staff members completed accident and incident forms. We saw that 13 incidents had been reported for the month of June 2018 and 17 for July 2018. The registered manager maintained an overview of all accidents and incidents in the home however the format of the monitoring tool did not help to indicate peak times that incidents happened or identify any triggers for incidents such as falls.

The home was not purpose-built and the accommodation was spread across three floors. There were two staff members on duty at night and we noted that the majority of the falls occurred during the night shift. Discussion was held with the registered manager about introducing more detailed reporting and undertaking a more robust investigation into incidents to enable them to identify actions needed to help keep people safe. For example, to identify if an additional staff member for evenings and early mornings would help to reduce the incidence of falls and better promote people's safety.

There was a lack of understanding about how to keep people safe from avoidable incidents. For example, we saw an incident form completed stating a person had sustained a small cut to their scalp. We explored this further with the registered manager who explained that the person had a very fragile scalp and sometimes just brushing the person's hair could result in a minor injury. The registered manager had not considered what actions could be taken to protect the person from this discomfort such as getting a softer hairbrush for example.

Risk assessments for such areas as the use of wheelchairs, the risk of falls, the risk of developing pressure ulcers, the use of mechanical hoists and the risk of malnutrition were not always detailed and did not clearly describe the controls in place to help mitigate risks to people's safety and well-being. The registered manager reported that a staff member had been tasked with reviewing the risk assessments for all 19 people who used the service to make sure that all areas of risk were identified and managed. The registered manager was not able to give us a timescale for the completion of this, they said that there were no resources available to bring in staff for supernumerary hours to undertake this task.

The environment was not always appropriate to promote people's safety. For example, there was a step down into the kitchen just inside the kitchen door. The kitchen door did not have any lock to prevent people from accessing the area whilst meals were being cooked. This meant that people were at potential risk from scalds and burns by entering a busy kitchen and from falling down the step. Staff told us that some people who used the service did access the kitchen, however the risk had not been assessed for these individuals.

The provider had replaced broken furniture in people bedrooms with bright, fresh and modern items. However, the corners of the cupboards were sharp, there were no risk assessments in place and no attempts had been made to protect people from the risk of hurting themselves.

The staff team was not sufficiently knowledgeable to promote people's safety in the event of a fire. The home had a recent inspection from the fire service and the provider had taken the necessary action to

comply with some safety requirements made. We asked staff members what they would do if a fire alarm sounded. Some staff told us they would ring 999 but that was the sum of their actions. Other staff told us they would locate the source of the fire by checking the fire panel and then support people to move to a safe zone away from the fire. Another staff member told us they were not at all sure and said that they needed to practice fire drills more to give them the confidence that they would do the right thing. Staff gave us mixed feedback about the equipment that was in the home to support them to help people move quickly to a place of safety.

People were supported to take their medicines by trained staff. A relative told us, "They often give my [relative] their medicines whilst I am there, they wait with [person] to make sure they take them." At the time of this inspection there was no dedicated clinical room so the medicine trolley was stationed in a communal corridor when not in use. However, the provider reported imminent plans to create a new staff office large enough to be able to safely store the medicine trolley within. Staff members confirmed they had received training in the safe administration of medicines and had their competency to do so checked by senior staff members. The registered manager and deputy undertook regular checks of the medicines to help ensure safe practices. We checked a random sample of eight boxed medicines and found that six agreed with the records maintained. However, in two cases we found that the number of tablets did not agree with the records so we could not be confident that people always received their medicines in line with the prescriber's instructions.

Overall the home appeared clean and the domestic staff were seen to work hard to maintain a clean environment for people. However, there were areas that needed further work and a deep clean. For example, in the corners of some toilets and bathrooms there was ingrained dirt which could not be removed despite staff attempting to during the inspection. A person used a specific lay back chair to help prevent them from falling, the chair had torn covering which meant it was no longer a wipe clean surface. Infection control audits were a tick box format, we reviewed the previous two month's audits and found they were not meaningful and did not indicate that any concerns had been identified or actions taken as a result.

Some of the staff team demonstrated a lack of understanding of infection control matters. For example, during the lunch service we observed two staff members walking through the dining room one carrying a soiled incontinence pad in a bag and another carrying soiled laundry. We brought this to the attention of the registered manager, the provider immediately ordered a new bin to house incontinence products upstairs and a laundry receptacle was placed upstairs.

We received mixed feedback about the staffing levels in the home. On the day of this inspection the lift was out of order awaiting repair which meant that some people were being supported in their upstairs rooms instead of downstairs in the communal areas. This understandably had an impact on staff deployment in the home however, throughout the course of the day we noted that there was a calm atmosphere in the home and that people received their care and support when they needed it and wanted it.

Records showed that people had not been supported to shower regularly and this was again said to be because staff did not have enough time to do this. People who used the service who had capacity to share their views said they did get support in this area eventually but for people who were not able to share their views there was nothing to indicate they had. Minutes of staff meetings acknowledged there had been shortfalls in this regard and emphasised the need to provide the support and document it accordingly however, this had not happened.

We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not taken all reasonable steps to ensure the

health and safety of people who used the service and to manage risks that may arise during care and treatment.

People told us that they felt safe living at Honister. One person told us they felt safe because the staff team looked after them well. A relative of a person who used the service told us that people were safe because the staff team knew them very well, understood their needs and the different ways that people communicated with them.

Staff had been trained in how to safeguard people from avoidable harm and were knowledgeable about the potential risks and signs of abuse. Staff were able to describe how they would report any concerns both within the organisation and outside to the local authority safeguarding team.
Information and guidance about how to report concerns, together with relevant contact numbers, was displayed in the home and was accessible to staff and visitors alike.

We checked a random sample of pressure mattresses for people who had been assessed as being at risk of developing pressure ulcers and we found that they were at the appropriate setting for their weight. Staff told us that people were assisted to reposition at appropriate intervals to help maintain their skin integrity and we saw that records were maintained to confirm when people had been assisted to reposition.

Some staff told us they felt there were enough staff available to help keep people safe however, some told us this was not the case. People's basic care needs were met however, there were no opportunities for engagement or activity provided for people because the staff team did not have the time to do this and there was no dedicated staffing resource for this. People's relatives told us they did not have concerns about staffing levels and that when they visited the home staff always seemed to be very busy but people's care needs appeared to be met in a timely manner.

Safe and effective recruitment practices were followed to make sure that all staff were of good character and suitable for the roles they performed at the service. We checked the recruitment records of two recently recruited staff and found that all the required documentation was in place including two written references and criminal record checks.

Requires Improvement

Is the service effective?

Our findings

Staff had not always received training and subsequent refresher training to support them to be able to care for people safely. This included basic core training such as infection control, dementia awareness, end of life care and falls prevention. The registered manager did not have autonomy to arrange training for the team and the provider had not approved requests to do so. The registered manager told us that there had not been sufficient staff available to be able to spare staff to go on training so planned courses were often cancelled. We were also advised that the provider did not pay staff to attend training sessions which did not encourage the team to be pro-active in this area.

The registered manager showed us that there was a programme of staff supervision in place however, they advised that this was not up to date due to lack of time available to undertake supervisions. We received mixed feedback about the support provided for the team and not all staff told us they were confident to go to the management for support.

This meant that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure staff had received the support, training, professional development and supervision necessary for them to carry out their role and responsibilities.

The provider had undertaken significant refurbishment work to improve the environment at Honister. This had brightened and freshened up the home however, the environment was bland and was not enabling for people who may live with dementia or sensory impairments. A well-designed environment, can help maintain people's abilities and provide meaningful engagement by providing essential prompts, accessibility and reduce risks to support a person with dementia. The social care institute for excellence (SCIE) recommends good, even, internal and external lighting, a clear and uncluttered interior design and contrasting colours for floors, walls and furniture to help to maximise people's independence. However, the environment at Honister did not signpost people to facilities such as toilets, did not include appropriate lighting to meet people's needs in their rooms at night and did not include contrasting areas to support people with dementia and visual impairments.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Seven of the sixteen staff employed to work at Honister had completed relevant training to give them the understanding of their role in protecting

people's rights in accordance with this legislation. The registered manager demonstrated some understanding of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. They had some awareness of what steps needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful however, further training would be beneficial in this area to help ensure that people's rights and interests were consistently promoted.

Our observations confirmed that staff explained what was happening and obtained people's consent before they provided day to day care and support. We noted that 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, and it was clear that people had been involved with making the decisions and, where appropriate, their family members as well.

People were provided with a good choice of food and they were supported to choose where they wanted to eat their meals. We noted that some people opted to eat in the communal dining room and some chose to eat in the lounge area or in the privacy of their rooms. People's specific dietary needs were clearly documented and respected. For example, people living with diabetes or coeliac disease or people who preferred to eat a vegetarian diet. People's weights were monitored to help identify any steady weight loss or gain, where an issue of concern was identified through this monitoring advice and guidance was sought from the GP.

We observed the lunchtime meal served in a communal dining room and we noted that people were provided with appropriate levels of support to help them eat and drink. This was done in a calm, relaxed and patient way that promoted people's independence as much as possible. We heard staff interacting with people in a kind and considerate manner indicating that nothing was too much trouble.

People's day to day health needs were met in a timely way and they had access to health care and social care professionals when necessary. Appropriate referrals were made to health and social care specialists as needed and there were regular visits to the home from dieticians, opticians and chiropodists. One relative said, "Staff have always been very good at recognising when [relative] is unwell and getting the necessary support, they also keep me informed." Another relative told us, "[Person's] health needs are well met, they (staff) are good at raising any concerns with the GP."

The management and staff team advised that staff accompanied people to hospital visits, especially where no family members were available to do so. However, this did have a negative effect on the running of the home as additional staff were not always made available to cover.

Requires Improvement

Is the service caring?

Our findings

People's confidentiality was not always promoted. People's care records were stored in a lockable office in order to maintain their dignity and confidentiality. The office door was fitted with bolts to help ensure unauthorised people would not be able to easily access the information stored within. However, we noted a number of occasions throughout the day where the door was unlocked when staff were not using it.

A metal filing cabinet was seen on the first floor landing and contained completed daily notes, medicines administration records, records of check undertaken at night and archived care plans. The cabinet was not lockable as it was broken which meant that any visitor to the home would be able to gain unauthorised access to people's personal and private information. The registered manager told us that there was nowhere else for this information to be stored and the provider told us they were not aware of the cabinet at all. The provider immediately arranged for the cabinet to be removed and ordered replacement storage for these items.

The environment throughout the home was not always warm and welcoming. The provider had undertaken significant refurbishment work since they had taken over the service and many areas had new flooring and had been repainted. However, the home lacked a homely touch in communal areas and people's individual bedrooms were not personalised.

At the time of this inspection there were no baths operational in the home. The provider was in the process of changing all bathrooms to wet rooms and the only existing bathroom was being used as storage pending being changed to a wet room. This meant that people did not have a choice between a bath or shower, the provider had not undertaken any consultation with the people who used the service to check that this is what they wanted.

There were aspects of the maintenance of the environment that did not promote people's dignity. For example, on the day of the inspection there were two bedrooms that had broken curtain rails, the registered manager advised that these had been broken four or five days prior to this inspection. The rooms faced out onto a residential development which meant that they were overlooked. To help promote the people's dignity staff had draped bed sheets over the windows during personal care delivery and at night. The registered manager advised that they did not have a budget for emergency repairs and had no autonomy to address this matter when it had happened. Once we alerted the provider to this matter they immediately purchased two curtain rails however, there had been a period of four days where these people's dignity had been compromised.

There was a lack of storage for people's incontinence items which meant their rooms were cluttered with these items. This did not serve to promote people's dignity in the event they had visitors. The registered manager reported that this was because these items were delivered three months at a time and there was nowhere else to store them. Additionally, we noted that some people had excessive amounts of creams and lotions on display in their rooms. The registered manager agreed that there was no need to have three dispensers of each out at any one time but again there was no available storage. This meant that people's

bedrooms were not tidy and relaxing places for them to spend their time.

People did not have bedside lights in their rooms. This had come about as a result of a safety concern where a person had placed an item over their bedside light to dry and the provider's response to this was to remove all beside lights. However, this meant that staff had to use overhead lights when providing care at night which disturbed people more than necessary and people who wished to have a small light at night to give them reassurance were left in the dark. The registered manager had requested plug in night-lights to address these issues in June 2018 but these had not been provided at the time of this inspection.

In the ground floor communal hallway we saw notices on the wall for the staff team, dispensers for gloves and aprons and air freshener aerosols. Not only did this not create a homely and respectful space for people but also caused a potential risk for people who lived with dementia should they access these items unobserved.

Some aspects of record keeping did not promote people's dignity. For example, a photograph had been taken of a person's pressure ulcer in order to be able to track progress with healing. We found that this photograph was stored in a transparent pocket in the person's care plan. The registered manager had failed to note that it would promote the person's dignity better if the photograph was stored in an envelope as opposed to a transparent pocket.

The above issues meant that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not provided care and treatment in a way that ensured their dignity was promoted and respected at all times.

People's relatives told us they were happy with the staff that provided people's care. One relative told us, "Staff always treat [person] with dignity and they are so caring. For example, if [person] is upset staff take their hand and stroke [person's] hair to soothe them. They have no end of patience and respect for [relative], they are super with them." A relative responding to a quality assurance survey had stated, "I am very impressed by the patience and kindness with which the staff attend to [person]." Another relative had responded, "The staff have always been caring friendly and efficient. They [staff] have taken good care of [person] since they arrived at Honister."

An independent advocate was involved to support two people living at Honister who did not have families to support them. For example, the advocate had arranged for a person to have access to a talking newspaper. Whilst this is positive for the person, it is an expectation that the care service would provide support in this area.

The registered manager gave us examples where care staff had gone above and beyond their job roles by doing things in their own time for the benefit of people who used the service. For example, at Christmas time, staff bought 'secret Santa' gifts for people because many didn't have any relatives. Another example given was when staff supported people to attend hospital appointments and were waiting for transport staff members liked to treat people to a drink and cake from the coffee shop. This was positive for people who used the service but many things are done by staff because they care rather than the provider demonstrating a caring ethos. For example, staff members attended funerals in their own time to show respect and support for those who had passed away and often bought flowers at their own expense.

Staff were calm and gentle in their approach towards people. One staff member told us, "I do believe that people do get good care here." The registered manager told us, "People are shown compassion and we care for our residents. Many of them don't have anyone else."

Staff respected people and made sure that they supported people in the way they wished whilst encouraging them to remain as independent as possible. During our inspection we noted that staff were always courteous and kind towards people they supported. We saw staff promoting people's dignity and privacy by knocking on doors and waiting before entering people's rooms. Throughout the day we noted there was good communication between staff and the people who used the service and they offered people choices.

Staff had developed positive and caring relationships with people they clearly knew well. People were relaxed and comfortable to approach and talk with care staff and domestic staff alike. We observed staff interact with people in a warm and caring manner listening to what they had to say and taking action where appropriate.

There were photographs of the staff team on display in the communal area of the home which meant that visitors and relatives were able to identify the staff on duty. We noted from the visitor's books that there was a limited flow of visitors into the home, the registered manager told us that relatives and friends of people who used the service were encouraged to visit at any time.

Requires Improvement

Is the service responsive?

Our findings

The registered manager advised that specific care plans were in place for people who were nearing end of life. However, we found that an end of life care plan had been placed in a person's care plan folder but had not been completed. There was no information available to support staff to meet any specific care and support needs the individual may have had at this time and to keep them as comfortable as possible in their final days. We discussed the need for the service to explore people's individual wishes in relation to their end of life care and to document if they had any specific wishes whilst people were able to contribute. The registered manager told us they felt that the staff team provided people with good support at this time for example, staff sat with people to provide comfort, read to people, played music for them and kept them as comfortable as possible.

People's care plans were not sufficiently detailed to be able to guide staff to provide their individual care needs. For example, one care plan we viewed stated, "One carer to assist [person] to wash and dress or, if they wish to shower or bath." Another care plan stated, "Two staff to assist with personal care." There was no information to guide staff members as how people wished their care to be delivered and no guidance to help ensure that the personal care provided for people was consistent. However, despite the lack of written guidance staff were knowledgeable about people's preferred routines, likes and dislikes, backgrounds and personal circumstances.

People did not always receive personal care that met their needs. For example, we reviewed records of bath and showers. Records were scant and failed to indicate who had been supported to have a shower and when. We also reviewed daily records and again could not find confirmation that people routinely received this care and support. The registered manager told us that they believed people had received the support but that staff did not always record it. The registered manager was not able to confirm if they had checked with people that they had received their support in line with their care plans. People we spoke with said they did not think they received this support regularly but said they could not be certain.

There were no activities taking place at the home during the course of the inspection. People had nothing to provide them with stimulation or engagement; people were slumped in their chairs asleep throughout the course of the day. Staff members told us that they were rarely able to facilitate any group or 1:1 activity sessions due to time restraints and having no dedicated staffing resource for activities. The registered manager told us that staff members often read newspapers to people or sat and chatted with them however, we did not observe this, the daily records did not confirm this and nor did people or staff that we spoke with. It was reported that some external entertainers came into the home regularly including an animal handling experience company, a company that specialised in reminiscence sessions and a musical entertainer. However, we were told that the provider was considering stopping this in favour of having an in house activity co-ordinator because they could not make funds available for both.

People's relatives told us that activities were an area of concern for them as nothing seemed to happen to brighten up people's daily lives. One relative told us, "There are no activities in the home, I can't remember the last time they even took my [relative] out into the garden for some fresh air. The front garden is not

wheelchair friendly and there is no nice area to sit anywhere outside. For the last six months there has been nothing going on there, it is miserable and upsets me very much." Another relative said, "We find it quite shocking that the activities have stopped. There seems to be a lot of cost cutting in many areas which is concerning. For example, finding cheaper hairdressers, and chiropodists and cutting important staff roles such as laundry service and activities. We have been told that the new owner will not bear the cost of an activity co-ordinator, they expect staff to do this along with the other duties they have to do." A further relative said that they were perturbed that people who used the service paid an additional payment of £20 per month towards activities but these were not happening.

People's relatives said they had not been involved in developing people's care plans even where people did not have the capacity to make their needs and wishes known themselves. There was nothing to show how people's care plans had been developed. One relative told us, "I have been through the care plan once but was not involved in developing it and I am not involved in any reviews."

We found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that each person received appropriate person-centred care and treatment based on their needs and preferences.

There were regular meetings scheduled for people who used the service and their relatives to share their opinions about the service and facilities provided at Honister. However, people's relatives did not routinely attend these meetings and very often there was just the one relative that attended.

The registered manager was in the process of investigating and managing a complaint made by a relative about difficulty they had experienced in contacting the home. The provider had an internet telephone facility which failed to work when the internet service failed. This was the only complaint recorded at the home, there was a post box for complaints or suggestions in the communal hallway but we were told this was never used. A discussion was held with the registered manager about ways of capturing people's verbal dissatisfaction as part of the quality assurance systems to help drive forward the quality of the service provided at Honister.

Inadequate

Is the service well-led?

Our findings

The registered manager had been in post since January 2018, this was their first management role and they lacked experience. The provider had not supported the registered manager with mentoring in their new role and had undertaken just one supervision with the registered manager since they had taken over the service in February 2018. The provider had responded when asked for help but they had not provided support for the registered manager to undertake day to day activities of managing the home. For example, providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The registered manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken. However, they had not been aware that these incidents also needed to be reported to social services.

There were ad hoc meetings held between the registered manager and the directors to discuss such issues as recruitment, the performance of the service and any matters arising. However, these were not documented and did not reflect how decisions had been reached or detail any actions identified for each party to complete.

The registered manager did not have any autonomy in the service, for example was not able to request agency support when short of staff. The registered manager did not have any agreed budgets to work with so was not able to manage the service for the best interests of the people who used it. For example, curtain rails had broken in two people's bedrooms, these were not able to be replaced until the provider attended the home five days later. This meant that people's dignity was compromised because the registered manager did not have autonomy to manage the day to day running of the service.

The provider did not use a dependency tool to calculate their staffing hour's requirements. We noted that senior care staff were included in the numbers on the rota to deliver hands on care and provide support for people with personal care needs. We found, and senior care staff confirmed that they administered people`s medicines in the morning as well as undertaking other tasks relating to management of the shift and supporting people's healthcare needs and therefore were not always available to provide care to people. The home was a converted building with accommodation spread over three floors which meant that two care staff on duty at night would not be able to effectively assure the safety of people and help prevent the incidents of falls.

The provider had failed to take positive action to support or encourage staff to undertake the training that staff needed in order to care for people safely. The registered manager did not have authority to book training for the staff team. The registered manager had asked for authority to book basic core training for the team since February 2018 and this had not been approved at the time of this inspection. Records showed, and staff members confirmed, that refresher training was overdue for the vast majority of the staff team in areas including infection control, nutrition, falls prevention, safeguarding and dementia care. We were advised that the provider did not pay staff attending induction shadow shifts or for attending training sessions.

Regular staff meetings had been held up until July 2018 to enable the team to discuss any issues arising in the home. However, we were told that the provider had ceased to pay staff to attend these so no further meetings had taken place. We viewed minutes of three meetings prior to July and noted that they did not reflect a two way process where staff were encouraged to participate towards bringing about improvements in the service. The minutes were a list of issues that had been identified as requiring improvement but did not evidence any staff involvement in how the improvements could be brought about. Staff found that the management team was not always approachable and felt they could not always ask for support when they needed it.

There were a range of checks undertaken to help ensure that the service was safe. These included such areas as infection control, medicines and care plans. However, these audits did not indicate where issues had been identified and did not provide clear information about action to be taken, by whom and within what timescales.

The registered manager and deputy manager reported that audits, supervision and care plan reviews had not always been completed in a timely manner because they did not have protected management time to undertake these duties. The registered manager did not have support from the deputy manager with routine management tasks because the deputy manager had to work on the floor alongside the staff team in the role of a senior carer in order to meet people's needs. The registered manager reported that because of having no administrative support their time was taken up with such tasks as routine audits, food shopping, chasing recruitment documentation, interviews for new staff, preparing staff rotas, preparing invoices, preparing for staff meetings and developing guidance documents for the home such as 'as needed' medicine protocols.

We found that quality monitoring was inconsistent, had not identified risks to people and had not led to action being taken to address areas of concern and mitigate risk to people`s health and wellbeing. Falls audits collated the number of falls over a period of a month for each person. However, although the information was available on the number of falls there was no indication that actions had been put in place to mitigate risk of further falls. There was nothing to evidence consideration of actions that could be taken to prevent reoccurrence. The registered manager and provider could not provide any evidence that they had effectively analysed the incident and accident reports for trends and patterns and that they had put actions in place to reduce the reoccurrence of falls.

The provider had failed to undertake quality checks of the service to satisfy themselves that the service they provided was safe, effective, caring, responsive and well-led. Two reports were submitted as part of this inspection process indicating that provider checks had been undertaken one in June and one in July 2018. However, these primarily addressed environmental and refurbishment matters that the provider was overseeing. One report indicated that some queries had been noted in accident reports and discussed with the registered manager however, there was no detail included to indicate what the queries were and what actions were to be taken. This showed that the provider did not have a clear overview of the service provided or actions needed to improve the quality of the service.

The provider had failed to act on advice given by the local authority at their annual inspection. The local authority representative had expressed concern that the staff team was small and there was no contingency plan in place in the event that the staff team was struck by illness for example. The local authority representative had asked the provider to engage a staff agency so that they would be able to provide cover in the event of an emergency. At the time of this inspection the provider had not done so. During the inspection the provider instructed the registered manager to act on this request to engage an agency however, they made it clear to the registered manager in our presence that agency staff were not to be used

without the provider's express permission as it was a costly resource. This meant that the registered manager did not have autonomy to engage agency staff in the event of staff shortages.

The provider had failed to act on advice given by an external professional in relation to equipment recommended to promote a person's safety. Information was shared with us by the local authority that an occupational therapist had assessed someone as being in need of a low profiling bed on 4 July 2018 and that it was the responsibility of the provider to purchase this. At the inspection we found that this purchase had not been made, we discussed this with the provider who immediately ordered the item on line.

The provider had failed to identify shortfalls found during this inspection process. For example, we noted that an area of flooring that had recently been replaced as part of the provider's refurbishment had been poorly fitted and had started to lift, flooring in another person's room was loose and created a trip hazard when staff had to move the bed to make it. Other issues identified but had not been acted upon included poor record keeping, out of date care plans and risk assessments, gaps in the staff training provision and a lack of activities to help keep people engaged. The registered manager reported that they had been aware of many of the issues identified but had not had the autonomy, authority or support to make the changes needed.

We found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because their governance systems were not effectively used to ensure the quality and the safety of the care people received was monitored and improved.

Relatives of people who used the service knew the registered manager by name and felt that they were approachable with any problems. One relative told us, "I do see the manager from time to time and if I ask to see them about anything they are always amenable. The home does seem to be well managed, everybody seems happy." Another relative said, "The registered manager is very friendly and approachable, they keep in regular contact with me."

The registered manager demonstrated an in-depth knowledge of the staff they employed and people who used the service. They were familiar with people's needs, personal circumstances, goals and family relationships.

The registered manager told us they were always open to suggestions from the staff team and that they listened to everybody. They gave an example where two staff members had come to them with a suggestion to swap the use of two communal areas around for the benefit of people.

A local care provider association had undertaken a quality assurance survey on behalf of the provider. The survey had canvassed opinion from people who used the service, their relatives, staff members and external professionals. A summary report of the outcome of the quality assurance questionnaire had not yet been sent to the service at the time of this inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that each person received appropriate person-centred care and treatment based on their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were provided with care and treatment in a way that ensured their dignity was promoted and respected at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken all reasonable steps to ensure the health and safety of people who used the service and to manage risks that may arise during care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to operate effective governance systems to assess, monitor and

drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service. The provider had failed to assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others. The provider had failed to securely maintain accurate, complete and detailed records in respect of each person using the service and the overall management of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff received the support, training, professional development and supervision necessary for them to carry out their role and responsibilities.