Seacole's Limited

Pelham House

Inspection report

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11 February 2016
12 February 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced inspection of this service on 10, 11 and 12 February 2016. The previous inspection took place on 18 February 2014 and found there were no breaches in legal requirements at that time.

This service provides accommodation and personal care for up to older 22 people. There were 21 people living at the service at the time of our inspection. The home is arranged over two floors, people had their own bedroom and access to the first floor is gained by stair lifts, making all areas of the home accessible to people.

The service had a registered manager in post who is also the provider. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection highlighted shortfalls where some regulations were not met. We also identified areas where improvement was required and made recommendations that the service should adopt.

Some practices for the receipt, administration, storage and disposal of medicines did not promote proper and safe management. This was because people did not always receive their prescribed medication; procedures for the receipt of medicines did not ensure staff knew when medicines were available for administration; guidance for the disposal of spoiled or obsolete medicines was not followed and procedures intended to ensure the correct storage temperatures of medicines were not in place.

People were not safeguarded against the risks of abuse because staff did not recognise or react appropriately to acts of neglect. Two referrals were made to the Local Authority Safeguarding Team as the result of this inspection because of concerns identified where medication was not administered as prescribed.

Some equipment used in the service was not adequately cleaned, placing people, staff and potentially visitors at risk of contracting acquired infections.

Some equipment used to support people with their mobility was not serviced when it should have been. This placed people at risk of injury because the equipment had not been certified as safe to use.

Aspects of recruitment processes were incomplete because decisions about the employment of some staff were not recorded.

Mental capacity assessments did not meet with the principles of the Mental Capacity Act 2005 and assessments contradicted other assessments held in people's care files.

Planning and delivery of training had not ensured a continuous learning process and staff lacked some skills and knowledge to support the people they cared for.

Advanced decisions about people's end of life wishes were not actioned which may result in people receiving resuscitation when they did not want to.

Staff lacked ownership and accountability for concerns they should have identified as part of their duties; this resulted in inactivity, placed people at unnecessary risk and did not demonstrate the culture of a caring service.

Elements of care planning did not fully establish some people's needs or reflect their wishes about how they wanted to be supported.

Quality assurance checks had failed to identify the concerns evident at this inspection; some records were inconsistent and incomplete and robust processes were not in place to ensure feedback received from people was acted upon.

Where the service had a legal obligation to notify the Commission of certain decisions and events, notification was not made.

People, visitors and staff spoke positively about the service and enjoyed being there.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breached the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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.

Medicines were not always suitably managed. The service failed to take sufficient or effective action to safeguard people from abuse and improper treatment as the result of poor management of medicines.

Risk assessments were in place; however, the measures needed to keep people safe were not always effective or fully developed. Incidents and accidents were not suitably investigated because risk assessments were not always changed to reduce the risk of them happening again.

Some equipment was not serviced when required; hot water management checks were ineffective and records of some key safety checks were incomplete or had not taken place. Aspects of the service were not suitably cleaned.

Recruitment checks were not effective because risk assessments required before employing some staff were incomplete.

Is the service effective?

Inadequate

The service was not effective.

Communication between staff was not always effective and decisions made by visiting healthcare professionals were not always implemented.

Planning and delivery of training had not ensured that staff had the required skills and knowledge to support people and recognise aspect of poor care.

Mental capacity assessments did not meet with the principles of the Mental Capacity Act 2005.

Staff received regular supervision; however, it did not introduce or reinforce a sense of responsibility for all staff to demonstrate the behaviours and work ethic of an effective, caring service.

People enjoyed the food provided and specialist requirements

were catered for.

Is the service caring?

Requires Improvement

The service was not always caring.

Action had not been taken to ensure that end of life advanced decisions would be met.

A lack of staff accountability and ability to recognise and react to poor care did not demonstrate the behaviours of a caring service.

Staff treated people respectfully and were compassionate and well-intentioned.

People and their visitors felt the service was friendly and welcoming.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some individual needs and preferences had not been established.

Changes in health and social needs were responded to and people felt staff were supportive of their needs.

People enjoyed the activities provided, however, the felt they would be enhanced by the presence of an activity coordinator.

An effective complaints system was in place; people and visitors were confident complaints would be listened to and dealt with effectively.

Is the service well-led?

Inadequate

The service was not well led.

The quality assurance framework was not fully effective and had not ensured continuous oversight of all aspects of the service.

Some records were incomplete which meant that recommendations made by visiting healthcare professionals were not acted upon.

The service sought the views of people about the quality of service provided, however, action taken to resolve issues was unclear.

The service had not notified the Commission of events or decisions where they had a legal obligation to do so.

Management of the service had not ensured its day to day values and behaviours were embedded into working practice or that poor practice was recognised and challenged.

Pelham House

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 in response to concerns raised with us, and 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.

We undertook an unannounced inspection of this service on 10,11 and 12February 2016. The inspection was undertaken by two inspectors.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for and interacted with staff. We looked in detail at care plans and examined records which related to the running of the service. We looked at six care plans and three staff files as well as staff training records and quality assurance documentation to support our findings. We looked at records that related to how the home was managed such as audits, policies and risk assessments. We also pathway tracked some people living at the home. This is when we look at care documentation in depth and obtain people's views on their day to day lives at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked around most areas of the service including some bedrooms, bathrooms, the lounge and dining areas as well as the kitchen and laundry area. During our inspection we spoke with seven people who live at the home, five visitors, two visiting social care professionals, three care staff, the home's cook and the deputy and registered managers.

We reviewed the information we held about the service. We considered information which had been shared with us by the local authority. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Inadequate

Is the service safe?

Our findings

People told us they felt safe and were happy living at Pelham House, Comments included, "The staff are nice, it's very pleasant here", "I believe I'm well looked after" and "I haven't had any concerns or problems". Visitors we spoke with felt they were usually kept up to date with the care and support their relative received. One visitor told us, "We like the atmosphere here. We looked at several homes and wanted her to come here. We feel at ease bringing the grandchildren here". Another visitor commented, "We chose this home because it is small and family oriented". However we identified some areas of practice which meant that the service was not safe.

Medicine management was not safe. We assessed the procedures for ordering, receipt, storage, administration, recording and disposal of medicines. A central medication stock room contained newly received medicines and also acted as a storage area for any medicines due to be returned to the pharmacy. Some medicines had been removed from their packaging and were left in a pot in the medicines room, they had not been booked into the returns system and staff were unclear why they were there or who they had belonged to. Similarly, an expired bottle of medicine remained in the stock room for a person who no longer lived at the service. Daily use medicines were stored in locked cabinets in people's bedrooms; however storage temperatures of medicines in the cabinets were not monitored or recorded. This presented a risk that medicine stored at an incorrect temperature may become desensitised and potentially ineffective.

Staff told us and records confirmed that there had been problems with the supply of some medicines from the pharmacy, this had meant that some people had not received the medicines they were prescribed. Staff told us any non-supply of medicines was followed up with the pharmacy; however, there was no record that this had happened. On one occasion, medicine received from the pharmacy was not recorded as received or administered to the person until four days after receipt. In total this person did not receive their prescribed medicine for 11 consecutive days. Another person, prescribed a daily laxative, did not receive their medicine on two occasions for five consecutive days or for six consecutive days on another occasion. A person who had recently moved to the service was not administered any of their morning medication on one occasion. Procedures within the service did not support people to receive medicines when they were available; people were placed at unnecessary risk because they did not receive their medication as prescribed.

Medicine administration records (MAR) were not always completed by staff when prescribed medicines were administered. The MAR is a part of a person's care records, staff are required to sign the record at the time that the medicine is administered or code the MAR correspondingly if medicines are not given or are refused. The failure to do so presents a risk that medicine has not been administered and that medicine may be incorrectly re-administered by another staff member. Some prescriptions on MAR charts had been updated and written by hand; the new entries were not always dated to know when they came into effect or double signed as an indication of a double check to make sure the information was correct.

Where medicines were given to people when needed (PRN), there was often no guidance in place to support this and records were incomplete. This presented the risk that medicines may not be administered consistently and safely by all staff. For example, in the case of variable amounts, the amount of medicine

given was not always recorded. Recording of how much was administered would help to make sure that too much was not taken within unsuitable timeframes. The service did not always keep records to indicate if topical creams had been applied. This made is difficult for staff to establish if they were administered as required. Medicine administration records did not always include a photograph of the person. This did not promote the safe administration of medicines.

People were at risk of unsafe care and treatment because risk assessments did not always record sufficient measures required to keep people safe. For example, a risk assessment noted one person should have a member of staff to support them when they mobilised. Accident records showed the person had fallen while unsupervised and sustained bruising. Although the risk of falling had been identified, appropriate measures were not in place; therefore, the risk of falling had not been suitably reduced. The risk assessment had not been reviewed following the fall and sufficient consideration was not given to alternative strategies; the risk of falling was not suitably mitigated. People were at risk of continuing injury and poor care because investigation of accidents and incidents did not reflect learning to minimise the risk to people of incidents happening again.

People were at risk associated with the unsafe administration and management of medicines. The provider had failed to ensure risk assessments recorded sufficient measures to keep people safe; that they were appropriately reviewed and did all that was reasonably possible to mitigate risks. This was a breach of Regulation 12 (1)(2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding policies and procedures were in place, accessible to staff and had been updated as needed. Staff spoken with told us they understood about keeping people safe from harm and protecting them from abuse. However, staff did not recognise their failure to correctly administer medicines or follow up on the non-administration of medicines represented neglect, a form of abuse. As the result of this inspection, two referrals were made to the Local Authority Safeguarding Team because people had not received their medication as prescribed. The failure of the service to take sufficient and effective action to ensure people received prescribed medicines meant people were not safeguarded from abuse and improper treatment.

The provider had failed to ensure care or treatment of service users was not provided in a way that significantly disregarded their needs and resulted in neglect. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of contracting acquired infections because some equipment used in the service was not clean or hygienic. For example, the frames and some toilet seats of commodes as well as toilet frames were not adequately cleaned; dried fluids and other bodily matter was evident.
Daily and deep cleaning schedules were in place and had been completed; however, the concerns identified during the inspection demonstrated that cleaning and infection control efforts and management were not adequate to ensure people lived in a clean and hygienic home.

People were at risk of accident and injury as equipment used by staff to assist people to move, such as a standing aid and a stair chair lift, were not subject to continuous maintenance arrangements and therefore could not be regarded as safe. Water temperature checks did not meet the requirement of the service's Legionella controls because no checks were made to ensure that water was heated to or circulated at the required temperatures. Checks intended to prevent the risks scalding were incomplete. They did not include all hot water outlets accessible to people or check maximum shower temperatures. Checks of fire detection and prevention equipment took place regularly, however, there were no records to confirm the checking or correct operation of automatic fire door guard mechanisms.

The provider had failed to ensure the service was suitably clean and hygienic or that equipment used at the service was checked when needed to help keep people safe. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected as far as practicably possible by a safe recruitment system. Records showed employment histories were checked, suitable references obtained and Disclosure and Barring Service checks (DBS) were undertaken when staff were recruited. However, where DBS checks disclosed convictions, although considered by senior management, the decision and any associated risk assessment to employ such staff was not recorded. We discussed this with the registered manager who gave an undertaking to immediately to address this issue. However, as systems in place were found incomplete, this did not promote the principles of a robust recruitment process to protect the safety of people living at the service. This is a breach Regulation 19 (1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient staff to meet people's needs. 21 people lived at the service and staffing was determined according to people's needs. Staffing comprised of three carers during the day shifts, in addition to a deputy manager and registered manager. Cleaning, cooking and maintenance was provided by ancillary staff. Night support was provided by two waking night staff. Staff, visitors and people at the service felt there were always enough staff on duty. There was little use of agency staff, as most shortfalls were met through use of existing staff. This helped to ensure consistency of care.

Fire drills were held regularly and staff were familiar with actions to keep people safe in the event of an emergency. Staff were provided with information about what to do in an emergency. Each person had a personal emergency evacuation plan detailing the support they needed to evacuate the building safely. Staff were aware of fire assembly points. A contingency plan was in place in the event that people could not immediately return to the service.

Inadequate

Is the service effective?

Our findings

People, their relatives and visitors were positive about the quality of care provided. People told us they had confidence in the staff who supported them, they felt staff understood their needs and knew how to meet them. Comments included, "They look after me well", "Staff are hardworking" and "All of the staff are very personable". People and their relatives said that staff communicated with them well. A visitor commented, "Staff are always welcoming, and are good at keeping me updated about how my relative is". Although people commented positively, we found aspects of the service were not effective.

People did not benefit from effective communication between staff to ensure some of their health needs were always monitored appropriately or that assessed needs were correctly supported. For example, a visiting physiotherapist had put an exercise programme in place for one person. However, care records did not show and staff could not confirm that the person was supported to do these exercises. A speech and language therapist had recommended the use of a drink thickener for one person to reduce the risk of them choking when drinking. In a subsequent visit, the therapist considered that the person's condition had improved to the extent that the drink thickener was no longer required; however, staff appeared unaware of this decision and the drink thickener continued to be used. Fluid charts had a running total of liquids consumed; however, they did not contain information relating to the expected fluid intake for an individual. Without such information, it was difficult for staff to establish if the required amount was achieved and therefore ensure effective hydration. When people were unable to be weighed regularly, staff were expected to calculate body mass index (BMI) based on the circumference of a person's upper arm. Although staff were aware of this procedure, they were unable to show us when these calculations had taken place. Therefore, these estimates of weight were at best a guess. This did not form a factual basis to establish a person's weight or to determine deterioration in their condition. Although staff handover notes advised that one person had not received their morning medication, this was not acted upon or any decisions recorded by the next staff shift. Poor communication meant that the person's needs were not met.

The provider had not ensured that care and treatment was appropriate and that it met people's needs. This is a breach of Regulation 9 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training records showed that some refresher training and mandatory training had not been delivered when needed. For example, the service employed 17 care staff including the registered manager and two deputy managers, only two staff had received training about Deprivation of Liberty Safeguards (DoLS); 13 staff required training or refresher training for the administration of medicine; 14 staff required training or refresher training for moving and handling as well as safeguarding and 11 staff required infection control training or refresher training. Although the registered manager was able to demonstrate that training was booked, scheduling and delivery had not provided continuous learning. Staff were not updated and trained with the skills and knowledge to effectively support people within their care; they had not recognised or reacted appropriately to safeguarding concerns, medicines were not safely administered or stored, DoLS and MCA practices were not embedded and staff had failed to recognise and maintain suitable cleaning and hygiene standards within the service. Given the client group of the service, insufficient emphasis was placed

on client specific training. For example, only three staff had current dementia awareness training.

Staff received individual supervisions every six to eight weeks and an annual appraisal; in addition, informal discussions were intended to keep staff up to date with any changes. Supervision was a one to one meeting with a manager; scheduled in advance and recorded when complete. The purpose of supervision was that staff should feel supported, are competent and maintain competence in their roles through effective management and identification of training needs. It is also an opportunity for supervisors to address unacceptable practices or cultures within the service and instil accountability by addressing any shortfalls identified through competence checks and the service's quality assurance processes. Regular supervision and appraisal took place, but processes failed to ensure staff were supported to acquire adequate training and skills to deliver care to an appropriate standard. Supervision failed to address issues of accountability where staff could have reasonably been expected to recognise and report, challenge or address poor practice, such as deficiencies in cleaning and hygiene of equipment and missing signatures and codes from MAR charts.

Staff had not received appropriate training to enable them to carry out the duties they are employed to perform; the provider had failed to ensure that staff received appropriate and effective supervision to make sure competence was maintained. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the DoLS, which form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place are intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS should ensure that the least restrictive methods are used.

Mental capacity assessments were not well developed or decision specific. In one case, the conclusion of whether a person had capacity was incorrect, based on the information recorded, and was contradictory to the findings in consideration of whether a Deprivation of Liberty Safeguards (DoLS) application was required. Staff had not correctly interpreted evidence recorded against four key questions within the Mental Capacity Act 2005 2005 in determining if the person had capacity to make a decision; additionally there was no indication of what decision was under consideration. Staff determined the person did not lack capacity; this was in spite of finding that they were unable to retain information for long enough to make a decision; they could not use or weigh up information as part of the process of making a decision and they could not communicate their decision effectively. Staff then incorrectly concluded that a DoLS application was not required because the person had capacity to consent to planned care and treatment. Staff were unclear about the application of mental capacity assessments and recognised, when pointed out, that the illustrated decision was incorrect and did not meet the requirements of the Mental Capacity Act 2005.

The service did not demonstrate an embedded understanding or practices which met the principles of the MCA 2005. This is a breach of Regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. Applications had been made to the local authority for seven people who were unable to leave the service without continuous supervision. Decisions about three of these applications were still pending.

People received a wide variety of homemade meals, fresh fruit and vegetables were available every day. People were provided with menu choices and specialist diets if required, they said the food was very good.

Some comments included, "The food is very good, there is plenty of it, the portion sizes are good", and "The food is first class, it's excellent. I can't say I would ever go hungry living here" One person told us if they did not like the menu choices for the day "I can ask for something else, there are always alternative choices and it's never a problem." A menu planner showed lunch and supper time meals and choices of desserts. There was a selection of breakfast choices and snacks were available at any time. Mid-morning and mid-afternoon drinks were served with a choice of biscuits or cakes. The food served was well presented, looked appetising and was plentiful. People were encouraged to eat independently and supported to eat when needed. Drinks were provided during meals together with choices of refreshments and snacks at other times of the day.

Requires Improvement

Is the service caring?

Our findings

People told us "I am comfortable and happy living here," and "They are very good to me". One visitor told us, "The home is always welcoming and staff are friendly." Another visitor's comments included, "You always feel the staff care," and "It is a caring atmosphere and welcoming home."
Care plans actively considered end of life wishes for people, however, staff did not always act on the wishes expressed. For example, staff had recorded one person's wishes that they did not want to be resuscitated; however, staff had not made appropriate arrangements to formalise the person's wishes and a do not attempt resuscitation (DNAR) decision was not in place. This meant, for example, should an ambulance crew, hospital or service staff be required to administer lifesaving support, without a DNAR in place, the person may be resuscitated against their wishes.
We recommend the service review practices to ensure they conform to published information, such as joint guidance issued by The British Medical Association, The Resuscitation Council (UK) and Royal College of Nursing recommended standards for recording decisions relating to Cardiopulmonary Resuscitation.

Although staff interactions were compassionate and well-intended; knowledge levels and a lack of awareness did not always enable staff to recognise poor care or respond in a meaningful way to some people's needs. For example, staff giving medicines will have seen gaps in records of administration. However, none had questioned whether medicines had been administered or recognised potential consequences of non-administration. Staff did not take ownership of concerns they conceivably should have identified. This did not assure consistent and safe care and did not demonstrate the ethics or behaviours of a caring service. This is an area we have identified as requiring improvement.

People were able to move around the home and sit where they wanted to. Several people told us they had made friends since moving to the home and spent time chatting together. Staff ensured people's privacy and dignity was maintained by carrying out personal care discreetly in people's own rooms or bathrooms. They knocked on doors and waited for a response before going in, showing their respect for people's private space. People were addressed by their chosen name and told us they got up and went to bed at the times they wished.

Staff talked about and treated people in a respectful manner. Staff knew people well; they treated them equally but as individuals. People felt staff understood their specific needs. Staff spoke affectionately about the people they cared for and were able to tell us about specific individual needs, their personalities and provide us with a good background about people's lives prior to living at the home; including what was important to people. Staff also gave examples of what might make a person distressed and what support they would give to relieve this. People's rooms were personalised with their own possessions, so that they could have their own things around them that were important to them. Interaction between staff and the people they supported was respectful but also light hearted, warm and friendly. Where English was not one person's first language, some staff had learnt key phrases, questions and used pictorial prompts to help ensure that the person could be understood.

Staff were patient and sensitive when giving information to people and explaining their support. We

observed staff making sure people understood what care and treatment was going to be delivered before commencing a task. For example, when giving medicine staff explained what the medicine was and checked if people wanted to have it and whether they wanted to receive it in the privacy of their own bedroom. They asked people whether they were experiencing pain and offered pain relief where people wanted this.

There was a calm and supportive atmosphere throughout mealtimes to ensure that people didn't feel rushed and were able to eat and drink what they wanted to. However, some people and visitors commented that the radio was on during meal times and this made conversation difficult. Staff checked if people had enjoyed their meal and asked regularly whether there was anything else they wanted.

Staff recognised people's visiting relatives and greeted them in a friendly manner and offered them drinks. Visitors told us they could speak to people in private if they wished and gave us positive comments about how well staff communicated with them, telling us staff always contacted them if they had any concerns about their family members. People's care plans showed that discussions took place at the time of admission to ask if their family members wished to be contacted in the event of any serious illness or accident. We saw where needed, this had happened.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and a local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt staff were responsive and supportive to their needs and were offered choice in all parts of their care. They felt confident about raising any concerns with the registered manager and were involved in discussions about their care plans if they wanted to be. One person told us, "I choose my own daily routine." Another person commented, "I can stay in my room and keep my own company". A relative told us they had never had to raise a complaint; they were kept informed about their relatives' care needs and were actively involved in the development of their care plan. However, another visitor told us their relative had not received foot care from the visiting podiatrist because they didn't have enough money to pay for this service. They were "surprised and disappointed" staff had not spoken to them to top up funds or resolved the issue in such a way that their relative received the treatment they required. The registered manager acknowledged the situation could have been handled differently and undertook to review practices in these circumstances. People said they were happy with the range of activities and particularly commented about the pleasant aspect the garden provided and how they enjoyed using it. None of the relatives raised any concerns at all about the quality of care people received from staff.

Pre-admission assessments were intended to ensure the service would be able to meet people's individual needs. These included all aspects of their care, and formed the basis for care planning after they moved to the home. Each person had a care plan. Their physical health, mental health and social care needs were assessed and care plans developed to meet those needs. Care plans included information about people's next of kin, medication, dietary needs and health care needs. However, we found aspects of care planning about incontinence were not sufficiently developed or adequately detailed to be individually meaningful. For example, support plans advised staff to promote continence. They were not personalised specifically for the people they were intended to support, they did not indicate people's daily routines, their preferences for support or the extent to which people may wish to manage their continence themselves. The support plans did not indicate the degree of incontinence or provide guidance about how people may wish their continence to be supported, such as, taking them to the toilet upon waking, prompting them to use the bathroom throughout the day or a plan to consider any other support required.

Individual needs and preferences had not been established. The provider had not designed care and treatment with a view to achieving people's preferences and ensuring their needs were met. This was a breach of Regulation 9 (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Short term care plans were written for people with acute conditions, for example, urinary infections. Care plans identified if people could communicate their needs clearly. Staff spoke about the importance of understanding body language, posture and facial expression in communicating effectively with people. Staff realised that difficulties in communication, being misunderstood or being in pain may cause some people to present behaviour that may challenge. There was information for staff on how to best communicate detailing simple instructions and short sentences to maximise communication. Throughout the inspection our observations showed staff were responsive to people's evident needs.

People told us they enjoyed the activities provided. Activities were provided by care staff as well as visiting

occupational therapists, musicians an aroma therapist and PAT dogs. People felt that there was usually enough to do. Staff were enthusiastic and spoke positively of their role in providing for people's social needs, but felt the service would benefit from dedicated activities staff as this would help to broaden the range of activities available. Staff delivered some activities on a one to one basis where this was more suited to these people's needs. Other activities were carried out with small groups of people. There was a good recognition of people's needs and ability to benefit or otherwise from group activities.

The service had a complaints procedure, which was available to people and visitors to see. It was also included in the information given to people and their relatives when they moved to the service. The procedure was clearly written; it contained details of different contacts, but also encouraged people to raise any concerns or complaints with staff or the registered manager. The registered manager had an 'open door' policy and made himself available to people and their relatives, this was evident during our inspection. There was a system for people to write down any concerns and staff told us how they would support people doing this. Documentation showed that all concerns and complaints were taken seriously, investigated, and responded to in a timely way. People were confident they could raise any concerns with the staff or the registered manager and said they would not hesitate to complain if they needed to. At the time of the inspection, the service was not dealing with any complaints.

Inadequate

Is the service well-led?

Our findings

A registered manager was in post. People, visitors and staff were complementary about the management team, commenting positively about how approachable they were. People told us they felt staff made time for them.

The registered manager (who is also the owner of the service) and key staff undertook regular checks of the service intended to make sure it was safe and met people's needs. These included areas such as infection control, medicine management, skin pressure care, nutrition, mobility and care plan quality. In addition audits helped to monitor and review the quality of service provided for people, the environment they lived in, care, leadership, operational processes and systems. However, the concerns identified during this inspection illustrated that the quality assurance framework in place were not fully effective. This was because they had not recognised or put measures in place to resolve areas where regulations were breached. These included issues relating to the storage, administration and disposal of medicines, reviews of risk assessments following an incident, incomplete risk assessment processes in relation to DBS disclosures, planning and delivery of training, servicing of equipment, inadequate water temperature checks and MCA processes. Therefore, systems had not ensured continuous oversight of all aspects of the service.

People's records were inconsistent and in some cases incomplete. For example, some care plans included specific areas intended to record visits from multi-disciplinary health and social care professionals such as speech and language therapists. Where a care plan did not contain this section, recommendations made by the speech and language therapist were missed and not acted upon. Similarly, recommendations made by a physiotherapist were also not acted upon. Records of the application of topical creams were not maintained and calculations of people's BMI when they were unable to be weighed were not made. Codes entered by staff in relation to personal care did not correspond to the key printed on forms and it was therefore not possible to definitively know what care had been given.

The service had systems in place to seek feedback from people, relatives, staff and stakeholders. They had completed annual questionnaires and resident meetings also took place quarterly. Responses to questionnaires and minutes of meetings contained mixed findings; people commented about mix ups in the laundry where they were given other people's clothes. Other comments included an activities coordinator should be employed as care staff can often be very busy and how the hygiene and presentation of the service could be improved. Although these comments formed recommendations and a basis for improvement, no timescales were set for their completion and no updates were available on progress made, this oversight was acknowledged by the deputy manager.

This inspection highlighted shortfalls in the service that had not been identified by monitoring systems in place in addition to incomplete records in respect of each service user and a failure to act on feedback received. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17(1)(2)(a)(b)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities).

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes when a service receives a decision from local authorities in response to an application made under Deprivation of Liberty Safeguards. This is where restrictions are needed to help keep people safe in the service. Statutory notifications informing us about four decisions had not been made to the Commission.

The registered person had not notified the Commission of events which they had a statutory obligation to do so. This is a breach of Regulation 4(A)(a) of the Care Quality
Commission (Registration) Regulations 2009.

The service's mission statement set out the principles of providing quality care. The deputy manager told us that the values and commitment of the home were expected to be demonstrated in the behaviours of staff. However, they recognised a shortfall in behaviours and culture of staff, around ownership and accountability for deficiencies that staff reasonably could have been expected to notice. Although staff recognised and understood the values of the home and could see how their behaviour and engagement with people affected their experiences; they were not embedded into every day practice. The management team had not effectively managed or reviewed the day to day culture in the service, including its values and behaviours. This meant they were not promoted by staff.

Staff told us the culture within the service was supportive and enabled them to feel able to raise issues and comment about the service or work practices. However, in practice, it was evident that this had not happened, particularly in relation to some of the concerns identified around medication and safeguarding. Communication was not open; it did not promote best practice or challenge poor practice; it did not ensure that responsibility and accountability were understood at all levels. This made it difficult for staff to understand what was expected from them.

There was a clear staffing structure. People knew the different roles and responsibilities of staff and who was responsible for decision making. Observations of staff interactions showed they felt comfortable with each other and there was a supportive relationship between staff at all levels. Staff worked together to achieve desired outcomes for people. For example, reviewing activities and discussing the health of a person who was unwell and suggesting actions needed to support them.

The registered manager belonged to an organisation that provides support and guidance about regulatory, policy and employment issues. This was intended to help the service keep up to date with current guidance and legislation.

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 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 18 Registration Regulations 2009 Notifications of other incidents Notification of other incidents. The registered person had not notified the Commission the outcome of requests to a supervisory body for standard authorisations under the Mental Capacity Act 2005. Regulation 18 (4)(a)(b) CQC (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person Centred Care. The provider had not ensured appropriate person centred care and treatment based on assessment of their needs and preferences. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Need for consent. Care and treatment of service users must only be provided with the consent of the relevant person, if the service user is unable to give consent because they lack capacity, the registered person must act in accordance with 2005 Mental Capacity Act. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Fit and proper persons employed. Recruitment procedures were not operated effectively to ensure people were protected as far as practicably possible by a safe recruitment system. Regulation 19 (1)(a)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing. The registered person did not ensure persons employed in the provision of a regulated activity received appropriate training as is necessary to enable them to carry out the duties they are employed to perform; the provider had failed to ensure that staff received appropriate and effective supervision to make sure competence was maintained. Regulation 18 (2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not taken steps to ensure that care and treatment was provided in a safe way for service users including assessing risks to their health and safety, doing all that is reasonably practicable to mitigate any such risks and ensuring the proper and safe management of medicines. Regulation 12 (1)(2)(a)(b)(g)

The enforcement action we took:

Warning

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from abuse and improper treatment. The provider had failed to ensure care or treatment of service users was not provided in a way that significantly disregarded their needs and resulted in neglect. Regulation 13(4)(d)(6)(d)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment. The registered person had not ensured that the premises and equipment was clean and properly maintained. The registered person did not in

	relation to premises and equipment maintain standards of hygiene appropriate for the purposes for which they were being used. Regulation 15 (1)(a)(e) (2)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good Governance Providers must operate effective systems or processes to ensure they are able to meet all requirements; assess, monitor and improve the quality and safety of services; mitigate against risks; maintain accurate and complete records; evaluate and improve their practice. Regulation 17(1)(2)(a)(b)(c)(f)

The enforcement action we took:

Warning Notice