Lillibet Court Limited

Lillibet Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 27 July 2016. It was unannounced.

Lillibet Manor is comprised of 34 single occupancy studio apartments within one converted building. The service provides a choice of assisted living, with Assured Short hold Tenancy provision and a choice of support options, or full residential care with accommodation and personal care, for adults of all ages who may have a range of needs. These include mental health, learning disabilities, physical disabilities, sensory impairments and dementia.

There were 28 people using the service at the time of this inspection, approximately half of whom received a full residential care service, whilst the remaining people had assisted living packages in place. The majority of the people receiving an assisted living package did not receive personal care, as regulated by us, the Care Quality Commission (CQC). Therefore information relating to them could not be included in this report.

The inspection was brought forward due to a number of concerns being received, including the impact created by the diverse range of conditions and associated needs amongst the people living at, and receiving care from the service. We also received concerns about staff attitudes and the food provided. We looked at these areas during this inspection and identified a number of concerns.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

A manager was in post and our records showed they had applied to register with us, the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated

Regulations.

Not all staff were clear about their responsibilities in terms of keeping people safe, and protecting them from avoidable harm and abuse. They had not received recent training to recognise signs of potential abuse, and were unable to describe all the types of abuse that people might experience.

People were being exposed to unnecessary risks, because identified risks associated with people's care, such as an increase in falls or weight loss, were not being managed appropriately. This impacted upon people's general health and well-being and meant that staff had failed to ensure appropriate control measures were in place to mitigate potential risk factors.

There were insufficient numbers of suitable staff to meet people's day to day needs. People had to wait for help when they called for assistance.

The provider had not carried out robust checks on new staff. We found that a number of legally required checks were not in place before new staff started working at the service. This meant the provider had not checked first to make sure staff were safe to work at the service.

Systems were in place to ensure people's daily medicines were managed in a safe way and that they got their medication when they needed it. However, we observed medication being administered that was unsafe, and was not in accordance with best practice guidelines.

People did not receive effective care because staff had not been equipped with the right skills and training to carry out their roles. The diverse range of needs people had, meant that staff had not been fully trained to provide them with appropriate care which met their needs in the right way.

We found inconsistencies in the way people's consent was sought in line with legislation and guidance. People were not always given the chance to make independent decisions.

There were concerns about whether some people had enough to eat and drink. Staff were not always clear about the importance of nutrition and hydration for those people the service was responsible for supporting with maintaining a healthy, balanced diet.

There were inconsistencies in the way people were supported to access relevant healthcare services. One person had not been referred to a healthcare professional despite staff being aware of a significant change in their health care needs.

People provided mixed responses about whether staff treated them with kindness and compassion. We found the approach from staff to be task orientated at times which meant that people were not always supported in a meaningful way.

People were not involved in making decisions about their care and support. This meant that their privacy and dignity was not always upheld or promoted. Some people also felt their level of independence had decreased since coming to the service, which in turn had deskilled them.

People did not receive personalised care that was appropriate to meet their needs. A number of people told us the mix of needs being catered for at the service was an issue for them and affected their day to day routines and experiences, such as meal times.

Although people told us activities had improved recently, significant improvements were still required to meet the different needs and ages of people living at the service.
Systems were in place for people to raise concerns about the service; however not everyone was familiar with the process.

Legally required information was not always reported to, or provided upon request, to the CQC. Quality monitoring systems and assurance processes had failed to identify this and a number of shortfalls in the service provided; with some people being placed at risk of harm as a result.

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

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 always safe.

Not all staff understood how to protect people from avoidable harm and abuse.

Identified risks associated with people's care were not being managed appropriately.

There were insufficient numbers of suitable staff to meet people's day to day needs and keep them safe.

The checks carried out on new staff to make sure they were suitable to work at the service, were not sufficiently robust.

People's medication was not always managed in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have the right skills and training to meet the needs of everyone living at the service.

Some staff were not clear about legislation and guidance in terms of seeking people's consent.

The arrangements to ensure people at risk of malnourishment had enough to eat and drink were not adequate.

There were inconsistencies in the way people were supported to access relevant healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

Interactions between staff and people were not always meaningful.

People were not always supported to make their own decisions as far as possible.

People's privacy and dignity was not consistently respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive personalised care that was responsive to their needs.

Improvements were needed to enable people to raise concerns or make a formal complaint, if they needed to.

Is the service well-led?

Inadequate

The service was not always well-led.

The service did not always promote a positive culture that was person centred, open and inclusive.

Legally required information was not always reported to, or provided upon request, to the CQC.

Systems in place to support the service to deliver good quality care had failed to identify and mitigate a number of risks to people's health, safety and welfare.

There was not a registered manager in post, although a new manager had been appointed and had applied to register with the CQC.

Lillibet Manor

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 27 July 2016. It was carried out by two inspectors, a specialist advisor - who had experience of working with people living with mental health conditions, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law.

In addition, we asked for feedback from the local authority, who have a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service. We spoke with eight people living in the service and observed the care being provided to a number of other people during key points of the day, including lunch time and when medication was being administered. We also spoke with the manager, deputy manager, two care members of staff, the cook, the finance manager, one relative and a visiting healthcare professional.

We then looked at care records for eight people, as well as other records relating to the running of the service - such as staff records, medication records, audits and meeting minutes; so that we could corroborate our findings and ensure the care being provided to people was appropriate for them.

Inadequate

Is the service safe?

Our findings

This inspection identified a number of concerns about the quality and safety of the care and support being provided.

Risk associated with people's care and support was not always managed positively, which meant that people were placed at risk. For example, one person, who had a history of falling, had a care plan in place to say they needed to wear a pendant alarm around their neck; to call for assistance if they fell and staff were not with them. They told us: "I am dead scared about falling about the place." We saw the person was not wearing the pendant alarm, and their relative confirmed this had been broken for at least a month; placing the person at possible risk in the event of them falling and being unable to call for assistance. The manager told us it had been sent away to be fixed, although they disputed that it had been broken for at least a month. The person's care plan had not been updated to reflect the fact that the pendant alarm was broken. Although there was no evidence that the person had fallen during this time, there was also no evidence of any measures being taken, such as additional staffing or a sensor mat; to mitigate the risks to the person in the interim.

We observed one person walking with a walking stick through some double doors. The doors closed quickly behind them, and caught their back. Although the person did not fall, there was potential to do so. They told us: "I have done that before. I am so unsteady on my feet now." We noted that the doors, and other doors around the building, had not been fitted with soft closers, meaning that they closed very quickly after being opened and posed a risk to people's safety. After the inspection the provider advised that some of the doors had been fitted with soft closers, where it was permitted and in accordance with fire regulation. They added however, that doors with soft closers are difficult for service users to open and as such not always appropriate.

Another person told us they were at risk of malnutrition and had been losing weight. Staff had completed a nutritional monitoring tool which highlighted that the person should be weighed weekly, to monitor their weight. We found the person had last been weighed on 26 April 2016, but there was nothing to show that they had been weighed since. The manager was unable to provide any more recent records. Staff also confirmed that food / fluid charts were not being maintained for anyone living at the service, in order to monitor their food and fluid intake. This meant that the person may have been placed at further risk of poor malnutrition during this period.

At lunch time we observed someone choking on their pudding. Staff explained that the person had problems swallowing and we heard them talking about the fact that the pudding had not been cut up sufficiently. We had observed the person's main course had been pureed, but the pudding, which was a sponge pudding, had only been roughly chopped up. The cook confirmed they did not have a list of people requiring special diets, including soft options, and that staff provided them with verbal updates about people's needs. When questioned, the cook was able to list the majority of people who required special diets, but not all, including one person who was at risk of malnutrition. This meant that people were being placed at risk of harm or not having their nutritional needs met, because insufficient information about their

assessed risks had been communicated to the cook.

We saw a member of staff administering medication, including a controlled drug. The service had recently moved over to an electronic medication system however, we observed the member of staff to 'sign' for the medication before administering it to the person in question. This was not in accordance with best practice guidance from the National Institute for Health and Care Excellence (NICE) which states that records should 'be completed as soon as possible after administration'. The staff member then asked for a second staff member to witness the administration of the medication by signing the electronic recording device, and checking the stock levels; to confirm the medication had been administered correctly. However, this member of staff had not actually seen the medication being given to the person in question so could not have known whether they had received it, or taken it. This highlighted concerns in terms of unsafe medication practices, placing people at risk of not receiving their medication as prescribed.

We observed an open storage box in the communal lounge which contained cleaning products. After lunch, someone living at the service took some cleaning fluid from the box to wipe down the tables. Although this was not a concern in terms of this particular person, we saw that there were also a number of people at the service who were living with dementia. We noted that the box and its contents were not supervised at all times, placing some people at possible risk of harm if they were to mistake the fluid for something else, such as a drink.

We found concerns with the systems in place to ensure the premises and equipment was managed and maintained in a way that ensured the safety of people, staff and visitors. For example, we saw that the seat on one of the two stair lifts was cracked, placing someone at possible risk if they were to use it. The manager was not aware of this when we reported it to her. The provider told us after the inspection that the stair lift had passed all its safety checks.

We also noted that a fire exit on the top floor had been blocked by a wheelchair and a hoist. The two items were on opposite sides of the corridor, which had significantly narrowed the access to the fire exit and placed people at possible risk in the event of a fire. In addition, the gas safety certificate for the service had expired on 16 June 2016. The manager confirmed after the inspection that a new gas check was due to take place on 4 August 2016, but this meant that people had been placed at possible risk of harm for almost two months.

People were further exposed to unnecessary risks in respect of their safety and security within the service because staff did not follow the provider processes consistently. For example, staff talked to us about safety and security at the service. One member of staff told us: "Oh yes, they will never get out that door. They have all got a call bell." Another staff member added: "The doors are locked. All visitors sign in and out." However we observed that during the inspection, a visiting healthcare professional came in without first signing in. In addition, when we arrived, we were let into the building by someone living at the service. They did not know who we were, or check with staff to make sure it was safe to let us in. We also noted that some people did not lock the front doors to their individual apartments, placing them at possible risk from potentially unsafe visitors to the service.

Records showed that individual evacuation plans were in place but were ineffective in supporting staff and the emergency services in the event of needing to evacuate people from the building in an emergency. Plans had not been updated or reviewed in the last two years, and we noted they lacked robust detail in terms of people's specific conditions and how these might present in the event of an emergency. In the case of one person who was at risk of falls, there was insufficient information about the equipment they might require in order to assist them to evacuate safely. In addition, none of the staff we spoke with were aware of an overall

emergency plan for the service. The manager confirmed there was no plan yet in place, which meant there was no clear plan to support staff in the event of an emergency such as a fire, flood, significant interruption to the delivery of the service such as a utility stoppage, or staff shortages.

These were breaches of Regulation 12 (1) (2) (a) (b) (c) (d) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there was insufficient staff on shift to meet their needs. One person told us: "No I don't think there are enough staff. When I came here it was agreed I would always have two staff, now I only have two staff to lift me with the hoist, and one of them has to go and leave me to get the other member of staff and it can be a little while." Another person said: "They are very busy and I don't like to say anything."

Many people reported concerns about the length of time it took staff to respond to their call bells. One person told us: "Several times when I ring the bell they don't come at all, then I don't feel safe. I could be on the floor." Another person told us: "I have been told to press the grey button, so I usually do. But sometimes they never come at all." We noted that the grey button the person was referring to was actually a reset button, so if pressed, would not alert staff to the fact they needed assistance. They added: "They make it very clear to me that they are not happy with me using the other bell (the red emergency button). I had waited 20 minutes before I used the red button the other day, they don't come." We observed in another person's room that the red emergency button on their call bell had been covered up with a piece of paper, to prevent them from using it. The manager was not able to provide an explanation for this when we asked.

Staff confirmed that they did leave people waiting for assistance, particularly where two staff were required for moving and handling transfers. One staff member told us: "We do have to leave people waiting, especially if we need another member of staff to help us. I do try and go and see them, turn the bell off and tell them I need to get someone else before I can move them. But most of them wear a pad anyway so they don't have accidents if they have to wait." Another staff member said: "I have to ask them to wait. I go in and reset the bell and tell them I am coming or tell them I need to get another member of staff. Sometimes, I can be clearing plates and people have to wait until I finish." On our arrival, we had experienced a long delay of almost 20 minutes before the front door was opened. Whilst we were waiting to gain access to the service another person living there, who had been out shopping, joined us. They told us they did not have a key, which was their choice, but confirmed it could take a while for staff to open the front door. This demonstrated that there were insufficient numbers of suitable staff to meet people's care needs.

Staff told us that sufficient numbers of staff were planned, but staff would phone in sick, leaving them short. One member of staff told us: "Enough staff are put on the rota, but they are not always here, like today." Another staff member added: "When we have 5 or 6 on the floor, then we have enough staff. We are short staffed today, so it is difficult." The manager confirmed she did not currently have a specific tool to assist her in calculating staffing requirements for the service, based on people's assessed needs. Rotas showed that six care staff had been planned for on the morning of the inspection, but this had reduced to five, when someone had phoned in sick. Additional support was provided on the day by the manager, a financial manager, the cook, a domestic and maintenance personnel.

Staff explained that some people living at the service were able to clean their own living space, whilst others paid extra for the care staff to support them with cleaning. Although the building appeared clean overall, we did detect a stale smell of urine in one person's bedroom. The person was also seen eating from a tray that was not clean, and their television remote control had a lot of dried food stuck on it. In addition, we saw a number of internal doors that were stained. This raised further concerns about staffing levels and whether they were sufficient to maintain a safe, hygienic environment.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that staffing had been tight earlier that month however; she had identified this as a concern and had recently introduced back to work interviews for staff, following a period of sickness. She told us she hoped this would assist her better in managing staff absence. She also told us that she was in the process of completing recruitment checks for one new member of staff which would then leave no staff vacancies.

The manager described the processes in place to ensure that safe recruitment practices were being followed; to ensure new staff were suitable to work with people living in the service. We were told that new staff did not take up employment until the appropriate checks such as, proof of identity, references and a satisfactory Disclosure and Barring Service [DBS] certificate had been obtained. However, we looked at a sample of staff records and found that legally required checks had not always been carried out prior to new staff working at the service. We found evidence of a number of staff starting work prior to them receiving a DBS check, or an interim check called an Adult First Check. This included the manager who told us she had started working at the service in February 2016. Rotas we looked at confirmed this.

Our records show that the provider had allowed the manager to start work by accepting a DBS check that she had completed through a previous employer in November 2015. In addition, records showed that the interim Adult First Check had not been completed for the manager until March 2016 and her DBS check also cleared shortly after that. This meant that the manager had been working at the service for almost three weeks without required checks being in place.

One staff member's file contained a negative reference from a previous employer, which clearly stated they would not be happy to re-employ them. There was no evidence that this had been followed up with the staff member in question or the previous employer, at the time; to establish whether the staff member was safe to work at the service. We also saw that some staff files did not contain a full employment history, which is also legally required. This meant that the systems in place to ensure new staff were suitable to work in the home, were not adequate and people had been placed at potential risk of harm as a result.

With the exception of the manager's DBS, we noted that the other gaps in employment records had happened before the current manager had been in post. The new manager showed us a matrix she had put together which had identified most of the deficits we had found within staff recruitment files. We saw that she had taken action to address these and the majority of legally required checks, including DBS checks, were now in place.

This was a breach of Regulation 19 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe living at the service. One person said: "Yes I think I do feel safe." Another person told us: "Oh yes I do feel safe. There is always someone around. I can go and get someone if I need them." Staff told us that people were safe too. One staff member told us: "They are, we just look after them properly."

Staff were clear that they would report any concerns to a line manager. One staff member said: "If I suspected abuse I would go without any hesitation to the manager with the information. I would keep asking to know what had happened about it and go higher if I was not satisfied." However, some staff were not fully clear on their responsibilities in terms of keeping people safe. One member of staff described a

safeguarding concern as: "Well it's anything, the way you talk to residents, if you talk without respect." They were not able to describe how they would protect people from abuse however. Other staff told us they had not received recent training to recognise signs of potential abuse, and were unable to describe the types of abuse that people might experience beyond verbal and physical abuse.

Meeting minutes showed that the manager had attempted to address deficits in staff knowledge by including safeguarding processes on the agenda at a recent staff meeting. She also told us she was in the process of reviewing staff training and would be arranging refresher training as required. We saw that information was on display which contained clear information about who to contact in the event of suspected abuse. Other records confirmed that the service followed locally agreed safeguarding protocols. There was also evidence of action being taken in response to safeguarding concerns, such as increasing staff presence in communal areas at key times to monitor people and help to keep them safe.

Staff talked to us about the new electronic medication system. They told us it would improve the safety of people using the service by reducing errors and enabling them to record, administer, monitor stock levels and audit medications within a single system. The manager explained that because the system was new, staff were still using paper records in addition to the electronic records, until such time that she felt confident that all staff were fully competent in managing the new system. We observed staff using the new system, which was dependent on a broadband connection to operate. We noted that there were problems in that the connection appeared erratic and the member of staff administering the medication needed to make more than one attempt to access some people's medication records. They confirmed the paper records would still be completed as a backup, until the broadband connection could be relied upon.

Medication was stored securely with appropriate facilities for controlled drugs and temperature sensitive medication. Records demonstrated staff had received medication training and that medication audits were taking place, to monitor the systems in place and identify any areas requiring improvement.

Requires Improvement

Is the service effective?

Our findings

People provided mixed feedback about whether the staff had the right skills and knowledge to do their job. One person said: "As far as I can tell they are (trained)." Another person added: "Some are better than others. If they are confident with the equipment (hoist) it makes me feel more confident and less scared."

Staff talked to us about the training they had received to carry out their roles. One staff member told us: "All my certificates were up to date." They told us that they had received no new training since commencing employment at the service therefore the provider had relied upon their previous training. They added: "I can't remember doing any DoLS training, I do have level 2 dementia training but I have not had any mental health training, I would like to do this." Another member of staff said: "I have done all the training here as it comes up, manual handling, first aid, and dementia. I have not done any mental health training or DoLS training."

The manager and deputy manager confirmed the names of 10 people using the service who were living with a variety of mental health conditions. All of the staff we spoke with confirmed they had not received any training in meeting people's mental health needs. This exposed people with mental health conditions, who received care from the service, to risk, as well as those around them because staff lacked the necessary skills and experience to support those needs. Staff told us they had learnt how to work with the people with mental health conditions over time however, the examples they provided were all in relation to managing risk and challenging behaviours as they occurred. They did not demonstrate a good understanding of how to manage these needs in a proactive way; identifying potential triggers and signs that could help to deescalate a situation before it arose.

We observed an incident at lunch time involving a staff member and a person living with a mental health condition. The person had refused their medication and had become aggressive towards the member of staff. The member of staff had organised for the person to have their lunch in their bedroom rather than in the communal dining room. The person was not happy with this and kept returning to the dining room, clearly agitated and unsettled. The member of staff reported that the person's G.P. and social worker had been informed about the person's behaviour and said they were waiting for further advice. They told us: "I don't think we are able to meet her needs here now." Staff that do not have training in mental health can feel nervous and unsure about supporting people with their mental health needs. It was evident that this staff member was not confident in managing this particular situation because they had not been equipped with the appropriate skills and training.

The manager told us that she had identified gaps in staff training and showed us she was working on a training matrix to establish how many gaps, and the areas these covered. We found that there was no clear overview of training already completed by staff, and training still required; in order to meet the assessed needs of the people living at the service. We therefore checked a sample of individual staff records to establish what training they had completed and did not find any evidence of training in mental health. We did find that staff had received training that was relevant to their roles such as nationally recognised health and social care qualifications, induction, pressure care, dementia awareness, moving and handling,

medication, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, we noted inconsistencies between staff files and the training courses completed by each staff member.

Some staff had difficulty in understanding us when we spoke with them because English was not their first language, and were not able to provide clear information regarding their understanding regarding safeguarding processes, people's specific nutritional requirements or how to meet these, or how to promote people's privacy and dignity. Although the staff members in question were noted to be kind and caring towards people using the service, this highlighted a further shortfall in staff training and support. The manager told us she used an external training company, who provided her with an overall assessment of each staff member's knowledge in each area trained, once completed. This did not demonstrate that the manager had satisfied herself that staff had sufficient knowledge and were competent to apply their new learning at the service however.

These were breaches of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us she was in the process of identifying staff to take on lead roles in areas such as dementia, mental health, safeguarding, infection control, falls and medication, who when trained, would help to improve staff knowledge and skills overall within the service.

Staff confirmed that staff meetings were being held; to enable the manager to meet with staff as a group, and to discuss good practice and potential areas for staff development. We saw evidence of these meetings happening and noted that actions had been taken in response to agenda items that had been discussed, in order to clarify staff roles and responsibilities. Some staff also told us that they had received supervision, which provided them with additional support in carrying out their roles and responsibilities, although they told us this had not happened on a regular basis. One staff member told us: "I was due for a meeting a few days ago, the meeting was cancelled [the manager] is very busy." Another staff member said: "I had my appraisal and supervision together last week – the first ones with this manager." Records we looked at supported the fact that supervision sessions had not been provided on a regular basis, but we noted an increase since the new manager had started working at the service.

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. We found that applications under DoLS arrangements had been submitted as required. The manager informed us that these had also been authorised by the local authority.

We also found that systems were in place to assess peoples' capacity, although assessments we looked at were not time or decision specific. This meant that assessments did not make clear what people were able to make decisions about, and what they needed more help with. For example, someone might have capacity to make decisions about what to wear every day, but they might not be able to cope with more complex areas such as managing their finances.

We found that staff did not have a good understanding of the Mental Capacity Act and none knew who was currently subject to DoLS arrangements. Some were also unsure about assessing people's capacity and when to initiate best interest decision processes. They told us they had not received recent training regarding MCA and DoLS. One staff member told us: "We don't have a place to log best interest decisions really. Everything is recorded in the daily log." Another added: "If they have capacity we would ask them what they would want us to do. If they don't we would speak to family members." This showed that staff did not recognise that unless someone's family member was their appointed Power of Attorney, then they had no legal rights to make decisions on the person's behalf.

Throughout the inspection we observed inconsistencies in the way that staff sought consent from people before providing care and support. One staff member was clear that if someone struggled to communicate verbally, then they would look for other signs of consent such as facial expressions and body language. Other staff were observed providing care and support with little regard to the people they were supporting. For example, we saw a member of staff wiping one person's face without any communication.

We also observed that when people were served their meal, that no one was offered the option to choose something different if they didn't like what had been provided to them. The cook confirmed that if she knew in advance that someone didn't like something, then they could provide an alternative for them, but this was the exception rather than the rule. This singular approach did not enable other people, including those unable to effectively verbalise their choices, to have the opportunity of experiencing the alternative meal provided too. When dessert was served, we noted that everyone was served sponge pudding with custard, despite cream being on the menu. No-one was offered an alternative, or given the choice not to have custard.

We also found a Do Not Attempt Cardiopulmonary Resuscitation (DNAR) form in place for one person that had been signed by a doctor. It had been ticked to say it had been discussed with the person, but there was no evidence of this as it had only been signed by the completing doctor and not the person. We could not clear if the person was aware of, or understood the reason for, the decision being made, and records showed that the person had capacity to make their own decisions. We also noted that a review section on the form had not been completed, meaning that there was no evidence that the decision was indefinite or had been revisited to see if it was still appropriate, if the person's needs had changed.

These were breaches of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the service was not responsible for supporting everyone living there with eating and drinking, as this depended on the type of care / support package they received. We spoke with some of the people who received food as part of their package and they reported mixed reviews regarding the choice and quality of food that they were served.

One person said: "The food is lovely; I think I've put on weight since I've been here". Another person added: "I eat it alright but there are many times when I am getting too much and it puts me off my food. Some say to me to leave it but others get funny with me when I don't eat it all." Everyone told us there was only one choice provided each meal time, and they were unable to choose an alternative. One person told us: "There is no choice - same for everyone. It's often not very hot, but what can you do?" Another person said: "Today was very good, but it isn't always. It often isn't hot, I just send it back…We do get some vegetables but not many. Fruit occasionally. I am losing weight very steadily going down. I do get weighed but no-one does anything to help me to stop losing weight."

Staff were not always clear about the importance of nutrition and hydration for those people the service was responsible for supporting with maintaining a healthy, balanced diet. For example, the cook told us she had not been provided with written information about who required a special diet, and relied on other staff to update her verbally. She told us: "They [staff] usually tell me if someone is losing or gaining weight, I don't know of anyone at the moment. Everyone is sort of stable at the moment." The cook was not able to describe how she might supplement people's diets if they required fortified diets; to minimise the risk of malnutrition. She spoke about giving people extra milkshakes, but was unable to tell us ways of providing additional nutrients and calories to people through everyday cooking.

Other staff were also not clear about the actions required to minimise the risk of people becoming malnourished or dehydrated. One staff member was able to tell us: "We weigh people monthly. If we have concerns we may weigh them weekly." However, they were not able to say what happened with the results of the weighing. The manager told us the service had recently failed to gain a 'Food First' certificate from the local Food First team. The Food First team works with care homes for older people to provide support in managing, those at risk of malnutrition using everyday foods. This demonstrated that staff did not have a robust working knowledge of how to meet people's nutritional needs appropriately.

We observed lunch and found the pace was not individualised, with one person being served their pudding before they had finished their main course, so it would have been cold by the time they came to eat it. Staff told us the person was a slow eater, but this had not been factored in in terms of how the courses were spaced out for them. Another person, who staff told us required a pureed diet, was seen choking and coughing up their food. We saw that the person's main course had been pureed but their pudding had only been cut up by hand. We heard one member of staff commenting on the fact that it had not been cut up enough. Although staff helped to clean the person up, they made no attempt to help the person to eat by blending the pudding.

Staff confirmed that food and fluid charts were not maintained for anyone at the current time to support them in monitoring food and fluid intake for those people assessed at risk of malnourishment or dehydration. We saw that people's weight had been monitored, to support staff in recognising potential health problems associated with weight loss or gain. However, we found that this had not happened for one person whose nutritional assessment had highlighted that they were at risk of malnourishment and needed to be weighed weekly. This meant that the arrangements in place to monitor those most at risk of malnourishment or dehydration were not adequate.

These were breaches of Regulation 14 (1) (2) (4) (a) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People provided mixed feedback about how the service supported them to maintain good health and have access to relevant healthcare services. One person told us: "They do get the doctor out if I am not feeling well." Another person told us they did not always understand the care and treatment choices available to them. They said: "They will I think (call the GP), but they go away and seem to talk about things." Three other people told us they needed to see an optician or the dentist, but they all told us that they relied on family members to take them to routine healthcare appointments. Records showed that for an additional fee, care staff would accompany them if they required, to attend appointments.

A record of visits to and from external health care professionals was maintained for each person, when the service called upon local community healthcare professionals, such as the district nursing team to provide specialist care and support.

Requires Improvement

Is the service caring?

Our findings

People provided mixed responses about whether staff treated them with kindness and compassion. One person told us: "They (the staff) are very friendly and very approachable." However, another person told us: "I keep losing things. I am not sure if I can remember where I put them or if they have been taken. I have stopped telling them (the staff) now because I don't think they believe me." A third person added: "One or two girls do pay a bit more attention than the others. It's all so routine; but they are polite and not rude. They are always in a hurry."

People told us that staff listened to them whilst providing care and support, but otherwise they did not have time to spend with them. One person told us: "They are very busy, that is not possible." During the inspection, we observed that staff spoke to service users with friendly familiarity however, communication was limited and task focussed. For example, telling people when their dinner was ready for them. When asked how staff got to know the people they were caring for, one staff member told us: "There are no procedures in place to carry out this one to one time with the service users. The deputy manager does all the care plans. I don't know if he talks to service users or not." This highlighted cultural concerns at the service, because staff were not aware that they needed to spend time with people to be caring and have concern for their wellbeing. Their task orientated approach was not conducive to an environment which promoted positive care interactions. After the inspection the provider confirmed that the assistant manager would always discuss someone's care plan with them when conducting a review of their needs, or when considering any changes to their care plan.

Staff were unable to describe how people were involved in making decisions about their care and support. They told us that they brought people with high dependency needs down to the main communal room; to help them in meeting people's needs faster. For example, if someone needed two staff to transfer. One staff member said: "The Oak Suite (the communal lounge / dining room) is where we take the more vulnerable residents for their breakfast; they stay there all day so that we are able to look after them." This approach didn't take account of people's individual choices and show that they had been involved in deciding where they would like to spend the day. This could be viewed as institutional practice.

We found people were not always given information and explanations they needed, in a way that they understood. One person told us they were frustrated because they were waiting to get their hair cut. Staff had told us earlier that the visiting hairdresser had cancelled, and would not be coming as planned. The person told us they had trouble remembering things and showed us a diary which helped them to remember important information. However, there was no evidence that staff had recorded in the diary or informed them of the change of plan regarding the hairdresser, as they were clearly still expecting the hairdresser to arrive. We were able to speak with the person's relative and it became clear that improvements were also required in terms of how changes at the service were communicated to family members. For example, we found that the person's keyworker had left, but the family had not been aware of this, or who the new key worker would be.

Everyone we spoke with told us they had a family member who was able to speak for them if required, and

records showed that people also had access to advocacy services where they required independent support, in areas such as benefits and completing forms.

People provided mixed feedback about how their privacy and dignity was respected. One person told us: "They put the towel over me when they give me a shower and they cover my lap with a towel in the chair. The blinds are still shut so no problem there." Other people told us their individual space was not always private however. One person talked to us about some of the people who were living with dementia at the service and told us: "They are walking about going into peoples' rooms."

Staff were able to tell us about how they protected people's privacy and dignity. One staff member told us: "During personal care we cover service users with a towel. We always close the door and curtains." However, observations during the inspection highlighted that people's dignity was not always upheld. One person was seen coughing and choking on their food, in front of other people whilst they ate their lunch in the communal dining room. Staff confirmed that this was a regular occurrence, but they told us they had not considered whether the person might like to eat somewhere more private, to promote their dignity.

Everyone told us friends and family were welcome to visit at any time. A relative confirmed this and told us they were a regular visitor at the home. It was evident that people were supported, as far as possible, to maintain important relationships with those close to them.

Requires Improvement

Is the service responsive?

Our findings

Staff told us that before people used the service, they were asked for information about their needs. This information was used to develop a care plan that reflected how each person wanted to receive their care and support. We reviewed care records and found that people had been asked for information about their needs prior to moving in.

We found a variety of people with different needs were living at the service, including people living with mental health conditions, learning disabilities and dementia, whose ages ranged from 44 to 98 years. It was clear during the inspection that the mix of needs being catered for was an issue for some people, and highlighted concerns about people's compatibility; particularly between those with a mental health condition and those living with dementia. One person told us they found some of the other people difficult in the way they ate, mumbled to themselves and generally not making sense when they spoke. They told us: "I try not to moan but when you eat breakfast together it can get you down." We noted that there was no separation within the service in terms of how care and support was provided to people with different needs. There was also only one communal area, which meant that if people did not want to socialise with other people, they were restricted to spending time in their own rooms.

People told us they had not been involved in the assessment and planning of their care. One person said: "I know they write in the book every day." However, they told us they did not know what had been written about them and said staff had not discussed this with them. This person's care plan stated that staff were to help them to maintain their communication. Other people told us they did not receive personalised care that was responsive to their needs. One person told us: "Well you are in their hands, if they don't come to you what can you do? They let you know without any doubt if they are not happy with you pressing the red bell and bothering them." Another person told us they were not offered personal care at times that suited them, which resulted in them sometimes declining care. Records we saw supported this.

Care plans did not demonstrate the involvement of the person they related to and some were less personalised than others. In addition, care plans we looked at provided instructions for staff to follow; to enable them to provide people with care and support that reflected their individual preferences. However, we noted that these were not always followed. For example, one person's care plan stated that staff did their cleaning once a week, with additional cleaning done as required. We observed that the plan was not being followed as the person's bathroom had been left in a very unhygienic state, which posed a risk of infection to them or anyone else needing to use this room.

Additional records were maintained to record the care and support provided to people on a daily basis, but these were often very basic in content and task orientated. For example, we read entries as brief as: 'Medication given'. This did not adequately demonstrate whether care and support had been provided in accordance with people's care plans and based upon people's current needs.

People's independence was not adequately promoted and supported. Care plans lacked information regarding people's individual goals and aspirations, for example, in terms of maintaining or furthering their

independent living skills. One person who had come to the service for a period of respite care told us they felt they had lost a lot of skills since being at the service, because tasks such as their laundry had been carried out without their involvement. They told us this had affected their confidence and independence and said: "When I'm at home I like to be busy, doing the washing and I cooked before, I did things for myself. I've lost that since I've been here, I'll need to build that up again when I get home."

Staff were unable to recognise the significance of this when we spoke to them about it. They did not take into account the fact the person would need to maintain a certain level of skills and independence, in order to succeed when they returned home. This meant that the provision of care was deskilling this person and would impact upon their ability to manage when they returned home.

People talked to us about their hobbies and social interests, and how they stayed occupied at the service. One person said: "I only have my TV to keep me occupied. I get the paper every day. I quite like my own company. There have not been any outings since I have been here. I would love to go out; it would be a nice change." Another person told us: "I am very lonely and I am bored really. I do read my paper but I look forward to the girls coming in so that I see someone, but the calls are very far apart."

Some people had noticed some recent improvements regarding activity provision, but said that more was needed. One person told us staff had started to run activity sessions, such as dancing and singing and they had really enjoyed them. They said: "They must keep that going." It was clear however from speaking with people, that activities had not yet been planned to reflect the different needs and ages of people living at the service. For example, one person told us their daily routine consisted of them dozing in the lounge, unless they volunteered to carry out tasks in order to keep busy. They added: "I'm not getting paid for it but it's better than falling asleep."

These were breaches of Regulation 9 (1) (2) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always clear about the formal process for making a complaint or raising a concern. They all told us they had not been provided with a copy of the organisation's complaints policy. After the inspection the provider told us that everyone had been provided with a copy of the complaints policy, and that a copy was also freely available within a policy and procedure folder at the front desk. One person told us: "I have complained to the carer about no-one coming when I call the bell. For a time they do seem to come when I call and reasonably quickly, but very soon it is back to normal. No difference."

We saw that information had been developed for people outlining the process they should follow if they had any concerns, and the manager showed us that a record of complaints and compliments was being maintained. We noted from this that concerns were taken seriously when they were reported, and people were kept updated on the actions taken in response. This showed that people were listened to and lessons learnt from their experiences, concerns and complaints.

We also read some correspondence sent recently from relatives to express thanks to the staff team for the kindness shown to them and their relatives. One relative had written: 'We love where mum is and the care she receives'. Another person had written: 'You are so calm, patient and caring'.

Inadequate

Is the service well-led?

Our findings

Quality monitoring systems and assurance processes had failed to identify a number of shortfalls in the service provided. This resulted in people not receiving a high quality, person centred service, with some people also being placed at risk of harm as a result.

People's care plans and risk assessments were not always accurate, or had not been updated to reflect people's current needs for example, when someone was at risk of falling or had received medical intervention. Steps had also not been taken to adequately mitigate identified risks relating to people's health, safety and welfare, such as monitoring of weight loss. This meant that some people continued to be placed at risk of harm, and further demonstrated the systems and processes in place to identify and assess risks to the health, safety and welfare of people, were ineffective.

We found that risks to people's health, safety and well-being were not appropriately mitigated, because staff had not been equipped with the necessary skills and training to effectively carry out their roles.

We observed that there was a diverse range of conditions and associated needs amongst the people living at, and receiving care from the service. The provider had failed to meet these needs because it did not ensure that staff had the necessary expertise, skills and training to meet the wide range of needs which existed, including dementia, mental health and learning disabilities. Without providing staff with the requisite skills and knowledge, some people did not have their care and support provided in a way that met their assessed needs or individual preferences. This placed them at risk of their health and wellbeing deteriorating and demonstrated a failure to monitor and improve the quality of service experienced by those people.

People were not always protected against the risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to regularly assess and monitor the quality of the service. We asked the manager about the quality assurance and auditing systems in place at the service; to monitor and drive improvement in the quality and safety of the service provided. She showed us that checks had taken place recently in areas such as the kitchen, medication, risk management, finances, infection control as well as some night spot checks. The checks did not however show that people's care records had been audited recently; to ensure the care and support being provided was appropriate to meet their assessed needs, and to monitor and mitigate any identified concerns in a timely way.

The provider had also failed to ensure that staff records were appropriately maintained and did not have sufficient oversight of whether staff had the right knowledge and were competent to apply learning gained at the service. This meant that quality assurance procedures failed to ensure people's health, safety and welfare was protected and promoted.

Systems to monitor and assess the quality and safety of the premises and equipment were inadequate. We saw that the gas safety certificate for the service had expired and a stair lift seat was cracked, placing someone at possible risk if they were to use it. The manager was not aware of these when we reported them

to her. This meant that the safety of people, staff and visitors had potentially been compromised, because these risks had not been identified through internal auditing and governance systems and therefore no improvements had been made.

Prior to the inspection we had been in contact with the provider on a number of occasions due to there being no nominated individual in place for over three months. A nominated individual is someone who is responsible for supervising the management of a service, and it is a legal requirement for registered organisations to have one in place. Eventually, we had to send a formal letter to the provider about this in order to receive a response; informing us that the manager of this service would be taking on the role.

The manager confirmed she had recently taken on the role of nominated individual, in addition to her role as manager. This meant that the manager would effectively be responsible for overseeing her own management of the service. Based on the findings from this inspection, there was evidence that in this case, the structure was not effective, and it was contributing to the failings at the service. The manager confirmed that although she provided support to the staff team through formal supervision sessions, she had not received formal supervision from anyone; to support her in carrying out her role and responsibilities.

The manager also told us there was no auditing tool yet in place to enable her to audit the service at provider level, so this was something that she would need to develop as part of her new role. This did not demonstrate that the provider's approach to quality was integral and that effective governance systems were used to drive continuous improvement.

These were breaches of Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The information CQC held showed that we had not always received all required notifications. We found that we had not received statutory notifications when a Deprivation of Liberty Safeguard (DoLS) application had been approved. A notification is information about important events which the service is required to send us by law in a timely way. The manager confirmed that three DoLS authorisations were currently in place for people living at the service.

This was a breach of Regulation 18 (1) (4B) of the Care Quality Commission (Registration) Regulations 2009.

Although the current manager had not been in post at the time of these applications being authorised, this highlighted further concerns with the adequacy of provider level oversight at the service, because monitoring systems and assurance processes had failed to identify and address this as a shortfall.

The service did not have a registered manager. A new manager had been appointed who had been in post for five months. Our records showed that she had applied to register with the Care Quality Commission (CQC) as manager, as required. Everyone we spoke with knew who the manager was, and told us she was very approachable. One person told us: "She is very friendly, a very nice lady." Staff also spoke positively about the manager and told us they were able to provide feedback to her, and felt listened to. One staff member gave an example of a recent suggestion for taking people out more regularly for a coffee and cake, which they said was starting to happen.

People told us there were opportunities for them to be involved in developing the service, which included attending meetings and completing satisfaction surveys. Staff told us that meetings took place for people living at the service usually every month. They told us the main topic of conversation was about food. Another staff member reported that people had complained at a previous meeting that they had too many

mushy peas. They added: "We have changed the brand of mushy peas now." A relative commented on the fact that there had not been a newsletter for a while so they were not familiar with some of the recent changes that had taken place at the service. The manager told us she had arranged a meeting for relatives but no one had turned up. Records we saw supported this. She said she planned to try again in September 2016.

We saw useful information around the service for people, staff and visitors, including information about safeguarding, suggestions and comments, policies and procedures and the last Care Quality Commission (CQC) inspection report and rating. We noted inconsistencies within some of the information and policies we looked at, because they contained the names of previous managers, such as the complaints process and the list of current fire wardens for the service, which might be confusing for people. The manager acknowledged this and said these would be updated. Other information had also been developed setting out what current and prospective users could expect from the service, their rights and also information about fees and the cost of any extra services. This demonstrated an open and transparent approach in terms of how information was provided to and communicated with people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Personal care	Some statutory notifications were not being submitted to the Care Quality Commission, as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Personal care	People did not consistently receive care and support that met their individual preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Personal care	Care and support was not always provided with the consent of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Personal care	The arrangements to manage and mitigate identified risks to people living at the service, were inadequate, and meant that people were being exposed to unnecessary risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

Personal care	The arrangements for meeting people's assessed nutritional needs were not adequate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes for assessing and monitoring the quality of service provided to people were inadequate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not sufficiently robust enough to ensure new staff were safe to work at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.