Cieves Limited

Gorselands Residential Home

Inspection report

25 Sandringham Road
Hunstanton
Norfolk
PE36 5DP

Tel: 01485532580

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12 July 2016 and was unannounced.

The home is registered to provide accommodation with personal care for up to 21 older people. On the day of our visit there were 19 people living at the home.

The nominated individual was currently overseeing the running of the home. A nominated individual is a person named by the organisation as responsible for supervising the management of the running of the service. This person is referred to as the 'provider' hereafter.

At the time of our inspection there was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There has not been a registered manager in post for three years. There have been care managers in post, but these have not registered with us.

People felt safe at the home and staff were knowledgeable about safeguarding adults and the different types of abuse to look out for. They knew what action to take if concerned about possible abuse.

The safety of people living at the home had been compromised on a number of occasions in terms of day to day care. There were not enough staff on duty to always meet people's needs or preferences. Care was delivered in a task orientated way rather than based on the person's individual need.

Some care records and risk assessments were not up to date and did not reflect changes in need for people living at the home. Risk had not always been assessed and appropriate steps were not always put in place to keep the person safe. Medicines were not always managed safely and staff did not have accurate notes to confirm if people had received their medicines.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The service was not acting in accordance with the principles of the MCA. People's capacity to make decisions had not always been assessed when there was a change to their mental health. Best interests decisions were not being made.

Staff sought consent from people regarding their immediate care needs. Staff had received training and said that most of the time they felt supported.

People living at the home received enough food and drink, and there was choice available at meal times. People health care needs were assessed, monitored and recorded, and referrals for assessment and treatment were made. Where people had appointments within healthcare services, staff supported them to

attend these.

People's rooms were decorated with their personal belongings so that they were comfortable and the area was made into their own space as much as possible. People's feelings were not always taken into consideration by staff, and sometimes people's dignity was affected because of this.

There were mixed feelings from people living at the home about raising concerns. Some people felt happy to do so whilst others were unsure if they would be listened too.

The provider did not have any effective systems in place to monitor the quality of the service or the running of the home. Health and safety audits were also out-of-date and evacuation plans for people were not easily accessible in the event of an emergency.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always enough staff to meet the needs of the people living at the home.

People were not protected from risk in a consistent manner and this was not always appropriately recorded.

Medicines were not given to people in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.
The Mental Capacity Act 2005 had not always been followed effectively to ensure people were supported to make decisions.

Staff had received training to ensure that they were able to meet people's needs effectively.
People were supported to maintain good health and had regular contact with health care professionals. They had sufficient to eat and drink and were involved in menu planning.

Is the service caring?

Requires Improvement

The service was not always caring.

Care planning was not updated to reflect people's needs and preferences, people were not always involved in care planning.

People were generally happy with the care they received. However, staff did not always consider the feelings of those that lived at the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not know always know about changes in need or preferences.

People did not always have access to regular activities.

People at the home had mixed experiences about raising concerns and complaints.

Is the service well-led?

Inadequate

The service is not well led.

There is no registered manager in post to oversee the running of the home.

The provider did not have effective quality assurance processes in place to monitor care being provided or the systems running the home.

Gorselands Residential Home

Detailed findings

Background to this inspection

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

This inspection visit took place on 12 July 2016 and was unannounced. The inspection team consisted of one inspector and one 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.

Before the inspection, the provider was asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider failed to return the PIR to us by the agreed date, and therefore we were unable to review this. We also looked at information we held about the provider. This included notifications, which are events that happened in the service, that the registered provider is required to tell us about. We also contacted social care professionals within the county for their views.

We spoke with five people living at the home and two visiting relatives. We also spoke with the provider (nominated individual), senior care worker, two care staff and the cook. We spent time observing the care provided to people during the day.□□

We reviewed the care plans of four people and staff records as well as a range of records relating to the way the quality of the service was assessed and monitored.

Requires Improvement

Is the service safe?

Our findings

People living at the home told us that they felt there were not enough staff and that they could not always respond to them when they needed assistance. One person told us, "They [staff] are busy so occasionally do not answer the buzzer as promptly as I need. I can just about get to the commode if there is a delay". Another person told us, "The staff are very nice and I only find them a bit touchy if I ring the bell and they are busy". Two of the five people we spoke to told us that they had to go to bed later that they wanted, one person said, "Sometimes I have had to wait to get to bed, 10pm occasionally. I understand why, it's because they are so busy".

Staff gave us varying opinions on staffing levels, one staff member told us, "Yes, there are enough staff" and another told us, "No, there are not enough staff to give the residents the time they need". However, staff told us that if they deviated from their routine, or something went wrong, such as an emergency, there were not enough staff to support all the people at the home. When we arrived at the home to carry out the inspection it took staff 15 minutes to answer the door.

We observed throughout our visit that there were long periods of time when people living at the home did not see a member of staff. For example, from 10.45am until 11.35am there were no staff in the lounge where the majority of people who lived at the home were seated. We witnessed two instances when staff went into the lounge, and at 10.45am all staff took a break together. Of the four care records that we reviewed, three people were assessed as being at a very high risk of falling and one a medium risk. Additionally we also saw in the accident book that some people had multiple falls in a short space of time. This meant that during this period there was insufficient supervision and support for people using the service, and therefore risks to their safety were increased.

Again at 1.45pm all staff were in the dining room writing their notes from their shift, leaving no one to interact with people at the home. In the afternoon a staff member brought a child to work with them. We observed that they cleaned the floor with the child present and then proceeded to 'watch' the singer whilst carrying the child. The child was on the premises with the staff member for 35 minutes. This meant that the staff member had to look after the needs of the child as well as support people, and this was a further 35 minutes where people had no interaction with a staff member.

The provider did not have a system in place for assessing the dependency levels of people living in the home. This meant that they could not determine how many staff were required on each shift to meet people's individual needs. Each person was allocated a generic amount of time for care to be delivered which did not allow for changes in their needs. The provider told us they were not planning to increase the staff levels.

At the time of our visit there were 19 people using the service, some of who were living with dementia. The staffing rotas showed that there was one senior and two care staff on in the morning, and then two staff care staff in the afternoon. Another member of staff came in over the tea time period to help with tea. At night there were two staff, one awake and one sleeping. To support staff to provide care, there was administration

support and a cook; there were also cleaning staff to support with housekeeping. On the day of our visit there were no cleaning staff and so care staff were covering the cleaning of the home. We observed that in one room there was a wet patch on the floor which had not been cleaned up, and the bath was dirty as staff had not had sufficient time to clean.

We concluded that the staffing levels were not sufficient to keep people safe, or for staff to be responsive to people's needs.

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

Risks to some people's safety had not consistently been assessed. Where they had been assessed, they had not always been reviewed following an incident. Therefore, the provider could not be assured that the actions in place to mitigate the risk were effective. This meant that staff did not always have the up to date information to reduce risk and respond in a safe manner should the need arise.

We viewed that in one person's care record they were at high risk of falls. As a result of this, the person had bed rails fitted to reduce the risk of them falling whilst in bed. The records showed that in June 2016 this person had climbed over the bed rails and fallen to the floor. There was a risk assessment in place in respect of the use of bed rails but the provider had not assessed whether they were safe to use. There had been no alternatives considered to reduce the risk of the person falling from bed. When we spoke with the provider they were unaware that this person's needs had changed over the previous months, or that alternatives had not been looked into. As a result, they could not tell us what action had been taken to safeguard the person in the future.

We saw in another person's record that the risks associated with changes in their continence needs had not been assessed or updated. This person did not like personal care to be undertaken, and as a result would go a full day without receiving care. Staff told us this person did not like personal care and that they may present behaviour that they found challenging. One staff member told us that this person often went to bed not having received appropriate personal care, throughout the day. There was no risk assessment or guidance for staff about how to respond to the behaviour so that this person received the personal care they needed. This meant that the person was placed at greater risk of health issues such as pressure areas and their care needs were not being met.

Staff knew that some people had pressure relieving equipment, and in some instances these were being used. However staff could not tell us why these were in place, or what they would do if the person was not using their equipment. One person's care record stated that their legs should be elevated to reduce pressure areas developing. Staff told us that they knew this should happen, but the person did not like having their legs elevated. Staff could not tell us what steps they had undertaken to lower the risks to this person or if they had referred the person to healthcare professionals to find alternative solutions.

Evacuation plans were not readily available for staff for dealing with people in an emergency. We were told that there should be a folder for staff with copies of the evacuation plans, however this could not be found. The provider told us that someone may have used it for their training and not put it back. There was a copy in the upstairs office, within the health and safety and fire records, however this was not be easily accessible for staff in an emergency. Some staff also told us that they had not been made aware of what to do in an emergency and did not know where evacuation plans were. This meant that in an emergency staff did not have sufficient knowledge or guidance that would enable them to safely manage the needs of all the people at the home.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Staff were able to tell us the risks to some people's safety. They were able to explain the equipment people used, and what they had to do to make care safe. We observed at our visit someone being transferred from their chair to a wheelchair using a hoist. This was carried out in a safe manner and by two staff.

People living at the home told us that they got their medicines when they needed them, with one person telling us, "I always get my medicines on time". And another who said, "I do receive my medication when I need it".

We saw that staff had received medication training, but they told us that their competency to do this safely had not been checked. We observed a medicine round and saw that two staff undertook the task together. The staff member who gave the person their medicine did not make sure that the person had taken it before leaving them. The other staff member signed the Medicines Administrations Record (MAR) to say it had been taken. This is poor practice. For example we saw that one person was given an aspirin tablet at 9.30am and at 10.45am this person had still not taken the tablet and staff prompted them, but again did not wait or encourage the person to take the medicine.

The provider told us that this was not the usual practice and staff should not be carrying out the medicine round in pairs. They however could not explain to us why this practice had gone unnoticed if it was not the home's policy.

Medicines were not always kept securely. During the medicines round, the phone rang and the staff member left the unlocked medicines cabinet to answer the phone. Therefore, people could gain access to the medicines which could have been unsafe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People told us that they felt safe living at the home. One person told us, "I do feel I am in a safe place here" and another person said, "When I need lifting there are always two to help and they use the hoist sometimes. They are gentle and careful and never hurt me".

Staff working at the home told us they understood how to safeguard people from the risk of abuse and harm. They said that they received training on safeguarding against harm, which we saw to be the case when we reviewed training records. Staff knew how to report concerns they may have to senior staff and were aware of the policy the home had to manage such incidents. The nominated individual could tell us the appropriate referral route for safeguarding concerns and confirmed the home had a policy in place.

The provider had systems in place to ensure they checked that prospective staff had the appropriate skills and qualifications to care for people before offering them employment at the service. For example, we saw people had completed application forms and the care manager had completed and documented interviews. The required checks had been completed to ensure that staff were safe to work with people who lived at the home.

Requires Improvement

Is the service effective?

Our findings

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 the service was not acting in accordance with the principles of the MCA. At the time of our visit there were no people who were subject to a DoLS authorisation or had a pending application. We saw in care records that people living at the home had received an assessment of their mental capacity, and most had capacity to make decisions. The practice of assessing people's capacity regardless of whether there is doubt about their ability to make a decision is not in line with the principles of the MCA. In some instances people were recorded as having fluctuating capacity. However, there were no clear care plans in place as to what to do at times when the person had reduced capacity.

We saw in people's care records that there were consent to care forms, and the majority of these has been signed by the person using the service. However in one person's care record a document had been signed by a relative. There was no indication as to why it was not signed by the person, who had signed other documents. In this person's care record there was no information that the relative had been asked by the person using the service to act on their behalf. Nor was there any evidence that the relative had legal authority to consent on their behalf. We checked this with the provider and they were unable to explain why the person had not signed the form themselves.

In one person's care record their mental health had been assessed as having deteriorated within the last year. It also stated that this person was living with a dementia and had fluctuating capacity. We saw this person had bed rails within their room and noted that on one occasion they had climbed over them and fallen to the floor. No assessment of the person's capacity had been undertaken to assess whether they were able to consent to this decision. In addition, there was no evidence that a best interests decision had been made in consultation with the person and others such as relatives or professionals. Therefore, this potentially restrictive practice may not have been the least restrictive or most appropriate option to keep the person safe.

Staff were aware that there was a MCA. But not all staff understood what a mental capacity assessment was and what that meant for people living at the home, but added that they had not yet had training. This was something that was booked in to happen in the next few months. Staff told us that this would improve their

knowledge and support them in their roles.

Our findings meant that the service was not acting in accordance with the principles of the MCA. Where people lacked the capacity to make decisions, there were no mental capacity assessments or best interests decisions in place. Staff did not have knowledge or demonstrate understanding of the MCA.

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

Staff told us that they had received supervision. However none of the staff we spoke to had received supervision this year. Staff told us that they felt supported by each other, and could speak to their senior for support. Senior care staff said that they were happy to talk through their issues with peers, if they felt they needed to. We spoke with the nominated individual who acknowledged that only two supervisions for all staff had taken place this year. This was because there is not a registered manager in place at the home and therefore these had not taken priority. The nominated individual told us that they observed care being delivered and spoke with staff that were not adhering to good practice. However, we observed poor practice during the medicines round that the nominated individual had not identified. Improvements are therefore required to ensure staff receive regular support from the nominated individual, to carry out their roles.

People spoke positively about the staff and their abilities and expressed confidence that staff were trained to meet their needs. One person told us, "The staff know what they are doing, so must be getting the right training". A visitor told us that, "[Their relative] was not very adaptable, but manages well here because of the efforts of the staff".

Staff told us that they received training and said that when training was due they accessed it easily. They told us that all the training they received was face-to-face training which they said was better for them, as they could exchange good practice and get tips from others. One staff member told us that during some moving and handling training the staff took turns in the hoist. This was so staff could understand what it felt like to be hoisted and better support people living at the home. New staff told us that they had been able to shadow more experienced staff members in order to learn about the home and the people that lived there. This was for three days and the nominated individual confirmed this. We viewed training records that showed that staff training was up-to-date and we saw that staff had covered the areas that the nominated individual felt were mandatory. This meant staff had access to training that supported them to effectively carry out their caring roles.

People living at the home told us that the food was good. One person told us, "The food is generally okay, especially the delicious Sunday roast" and another said, "There is plenty to eat, and I can have a snack when I want". One visitor told us that, "[Their relative] has a big appetite and they certainly cater for his needs, with extra portions if they want them". Additionally people told us that they could have a drink at any time as well, with one person telling us, "There is always a drink by my side".

Staff told us, and we saw that they spoke with each person in the morning and asked them what they wanted for breakfast and what choice they wanted for lunch. If people did not like what was on offer they could have something different. No one at the time of our visit was at risk of not getting enough to drink or eat. The home could not effectively monitor people's weights, as the scales were not in use. Staff were meant to measure people to ensure they had not lost weight. We saw in care records that each month the form to record this had been signed but no information had been added. This meant staff were not always able to determine if someone's weight had changed. The provider informed us that they were purchasing new scales to make this easier for staff to monitor people's weights.

No one at the home required alternative meal preparation and people were independent with eating when we observed lunch. The kitchen staff confirmed that they received information about people's likes and dislikes.

The staff supported people with their healthcare needs. People told us that they could access chiropody services at the home, and care records showed this and other appointments that had been made. For example, we saw that people had access to optician's appointments, health and dental appointments and were referred to specialists when necessary. Staff told us that they felt confident to contact healthcare or social care professionals if they needed too.

Requires Improvement

Is the service caring?

Our findings

The home has in place a Statement of Purpose; this is a document that shows how the home is run and the values of the service. The homes Statement of Purpose says, 'We will establish and implement individual care plans that recognise the needs of the resident by involving the resident in compiling the plan of care'. However, people living at the home told us that they were not involved in their care planning. One person told us, "I have no idea whatsoever what a care plan is" and another person told us, "I am not involved in planning my care". We did observe when we reviewed care records, that some records contained a note to show that staff had discussed the plan with the person and this was signed by the person. Those care records that contained this information had these reviews undertaken in 2015. The subsequent reviews of care in 2016 did not always indicate any involvement from people at the home.

People told us that they were mostly happy with the care provided by staff. One person said, "They are a damn fine crew here", and another person told us, "The day starts off well. In comes a cup of tea and the carer says 'hello trouble, another day and another cup of tea', it makes me smile". Visitors confirmed this to us by saying, "The staff are so caring, and as visitors we are always offered a coffee". Staff told us that this is, "Their home, we are one big family" which was confirmed by people living at the home. One person told us "We have a good laugh sometimes, which makes it feel like a happy family". One person was worried about moving into a care home, but told us, "I thought I'd hate moving into a home, but I have been made very comfortable here". This showed us that staff did on occasion take the time to alleviate people's worries and encourage them to settle in well.

During our visit we saw that staff were encouraging and gentle with people living at the home. We saw that staff knew people and what was important to them. For example one person liked to have a blanket with them at all times, and we observed that staff ensured it was in place. Staff told us about the histories of the people living at the home, and told us they felt it was important to know this information. This was so they could engage the person in meaningful conversation and learn more to create a caring relationship.

We observed that care records contained a detailed history of the person which staff told us was developed with the person. Staff also told us that they encouraged people to make choices about their every day care needs, and tried to encourage independence. Staff told us that they would offer a person an item such as a flannel to carry out an element of care themselves. If they did not feel they could manage the task that day, they would support the person. People living at the home confirmed this to be the case, one person told us, "I am encouraged to do things for myself" and another said, "Carer's will help me willingly if I am in a muddle, but they definitely like me to do things for myself". This showed us that staff were reassuring when delivering care, but also encouraged independence and enabled people to feel in control of their care.

However, there were some occasions where staff did not stop to consider the feelings of people. One person told us, "There is only one staff member who seems to ignore you, they just talk to the other carer they are working with". In addition to this when we brought to the attention a slight odour near a person's room, the staff member replied with, "That's our [resident] I am afraid" and no consideration was given to how that may make them feel. We also observed that staff were very task orientated throughout the day, which meant

they were focused on maintaining routine rather than spending time sitting and talking to the people at the home. We spoke to the provider about this who told us that staff were meant to spend time with people, however staff told us that they did not always have time to spend sitting with people.

Two people were sharing a room on the day of our visit. We saw that their privacy was protected with the use of a screen, which the person and staff confirmed were used. One of the people who shared a room told us, "I have to share a room which I don't like, but they tell me they are full and I can't move". When we spoke with the nominated individual regarding this, they told us that they had reviewed this recently with the person, and they had not said this to them. The provider confirmed they would revisit this with the person, to ensure they were receiving care that was individual to their needs.

One person told us that staff did not always arrive to support them promptly if they called for assistance. This person told us that they could only just get to the toilet on time, this put the person's dignity at risk if they were unable to make it on time.

Other people told us that they were happy and that they were respected and one person told us that, "They [staff] are so cheerful and treat everyone respectfully". We saw from one person's care records that they liked the door to be open when they were receiving care. Staff were able to tell us that they positioned the person so they were not in full view of the door, but could still see it was open. This meant that their preferences were met, but in a dignified manner. Staff were also able to explain to us the importance of observing people's privacy and dignity, and explained that they would close curtains, and always ask people before delivering a task.

Requires Improvement

Is the service responsive?

Our findings

People told us that because of a lack of staff, they had to go to bed later than they wanted as staff were often too busy. One person told us, "I'm never quite sure when my bedtime will be. I prefer an early time but it's usually 9pm. One night it was 10pm and I told them I wasn't happy but they said they were extra busy and couldn't get round and didn't seem too happy with me. I get a bit upset and so tired having to wait but I know they are busy and I suppose I have to wait my turn". Another person told us, "Normally things go well, but this week I should have had a shower, but no one came to take me". This meant that people's preferences were not always being met. Additionally one person wanted to go to bed earlier in the evenings as they found the evenings boring. Staff had informed them that they could not go to bed earlier due to their medication times. However, there had been no attempt made by staff to find alternative things for this person to do as they were fulfilling care requirements for other people during this time. No consideration had been made as to whether this person was able to take their medication when in bed, if this was their preference and was appropriate.

Staff told us that they found the care records to be useful and that they signed them to say that they had read them. In all of the care records we viewed, each did have a sheet within them for staff to sign to confirm they had been read, however none of these were signed. We spoke to staff about some people's needs as documented in the care records. Staff were not always able to tell us what people's assessed needs were. This indicated that they did not use the care records to support them when caring for people at the home Staff therefore did not always know if changes had been made to people's care. When we spoke with the provider regarding this, they were unaware that staff were not signing care records and could not confirm if staff utilised care records effectively. This meant the provider could not confirm if staff were meeting people's current needs.

We observed that care was task orientated and staff had a set routine to deliver care. This was not centred on people's individual needs. Therefore, if people requested support outside of this routine they were not able to receive it. For example we saw that in the 25 minutes before lunch was served, staff took each person to the bathroom. They did not ask the person before if they wanted to go, and no one had been asked during the morning. One person was distressed using the bathroom as they liked to have the door open, and therefore would not go. Staff did not offer to take the person to another bathroom where their care could be undertaken to the preference.

We reviewed the care records of four people who lived at the home. We saw that where there had been a change in a person's care requirements, their individual care needs had not always been re-assessed or appropriate guidance put in place for staff to follow. For example, we saw in one person's care record that in February 2016, it had been noted that this person had shown signs of changes in behaviour. No action had been taken to investigate the reason for the change. The plans of care in place had not been updated and there was no evidence that this had been discussed with the person or their family. Staff were unable to support this person with their behaviour in order to deliver their care. Consequently, their needs were not being met. This meant that the care people received was not individual to their needs, and staff did not have the correct individualised information to support the person appropriately.

People living at the home told us that they did not feel their days were very fulfilling and that activities were not very interesting. One person did tell us that they had recently enjoyed the summer party at the home, however this was the only positive comment we received. For example one person told us, "To be honest, the days are a bit monotonous as there's not a lot to do. When I get up in the morning I feel a bit neglected and sit around doing nothing. It's like that every day". Another person told us, "I get involved in activities if there is something interesting happening, but there's not that much going on. When I first looked around I wasn't sure I wanted to come here because I was not happy seeing people sat in the lounge doing nothing. When I saw my room and realised it was quiet and private, I realised it would work for me". A visitor told us, "It's a small home so maybe it's difficult to offer lots of activities".

We observed at the visit that there was a formal programme of activities that were booked by a staff member. This staff member had the responsibility for the activities plan for the home, this included booking religious services at the home to support people to meet their religious needs.

One person told us that they preferred to stay in their room because, "The others [residents] who spend the day in the lounge are all asleep with the TV on. I can't be doing with sitting amongst all that. My own TV is a better companion than the people in the lounge". Staff confirmed that most people spent the majority of the day asleep and they let them sleep if they wanted to. We observed that when the visiting singer was performing nine out of the 12 people in the lounge were asleep. Staff were dancing along but were not interacting with people, or encouraging those that were sleeping to join in. People were left in the lounge for long periods of time with no interaction from staff. Often the music or the TV would stop and there would be only silence in the lounge.

This is a breach of Regulation 9 of the Health and Social Care Act 2001 (Regulated Activities) 2014.

However, some people told us that they did have some of their choices met. For example one person still liked to visit the community and pursue a hobby they had observed throughout their life. Staff encouraged this, and we saw on our visit that this person went out independently to an event. One person told us that they were able to, "Get up and go to bed when they want" and another told us, "I have a bath on a Sunday, as I want". This showed us that sometimes staff respected individual choices and supported to make sure people got the care they wanted and when.

Some people told us that they did not always feel they were asked for their opinion about their care, or would feel confident to raise a concern. However, some people felt more able to raise concerns. For example one person told us, "I've not been asked my opinion about the place" and another person said, "This is not the sort of place where they would respond if I wasn't happy with something". However, a person did tell us, "I don't need to complain but knowing everyone as I do, I am sure they would try and put it right". A visitor confirmed this view, by saying to us, "I have been asked informally if we have any concerns". This suggests that not all people felt confident to speak up about the care they received, and therefore their preferences and needs had not been met.

The activities board showed that the next annual 'residents meeting' was due to be held in July 2016. People living at the home told us that there had been a meeting, but it was a while ago. We saw from records that this meeting had taken place in July 2015, and the records showed that the staff had spoken with people regarding the menus and activities. This was the only formal opportunity outside of care reviews for people to raise their concerns. There is also an annual questionnaire which was last completed in 2015. There were no specific issues within this questionnaire response, and a list of actions had been noted along with changes made by the nominated individual.

There was a complaints procedure in place and we saw there had been one complaint made in the last 12 months. This had been dealt with promptly and appropriately and the person who made the complaint was satisfied

Inadequate

Is the service well-led?

Our findings

People living at the home knew the provider and recognised them and greeted them when they arrived. The provider showed knowledge of the people living at the home. However, people living at the home did not always feel that the home was overseen by the provider. One person told us, "The carer's seem to run the place", and another said, "The place seems to run okay, but the staff do seem very busy". The observations that we made during our visit were that staff were not sure who was managing the home, or that there was strong leadership for staff at this present time. When we spoke to the provider regarding some of the practices staff were undertaking, they did not seem to know that these had been happening.

At the time of our inspection there was no registered manager at the home. The home has had a number of managers in the past three years none of whom have registered with the CQC. This meant that there was consistent leadership for staff on a daily basis. The Statement of Purpose for the home states, 'Ensure the management and administration systems are operated through excellent leadership by ensuring policies and procedures are implemented effectively'. Due to the lack of leadership some poor practice used by the staff had not been observed by the provider and therefore no action had been taken to make improvements in staff practice. For example in medicines administration which placed people at risk of harm. The lack of day-to-day management meant that certain records had been misplaced including the individual personal evacuation plans which again, placed people at risk of harm if an emergency was to happen.

The provider told us that they have struggled to recruit a registered manager that has fulfilled the requirements of the post. However, despite allowing some additional time for administration tasks by a staff member, this had not supported staff to maintain the high standards that the home advertises.

We found that the provider had a system in place to monitor quality but it was not effective. The provider told us that there were a number of audits in place that were there to monitor the overall quality of the service. When we looked at these records, they were either incomplete or out-of-date. For example, we requested to see the falls audit, as falls diaries in care records had not been completed and some people were at a high risk of falling. The falls audit had not been completed since March 2016, and therefore we could only view the accident book that was filled in by staff. Within this accident book we saw that one person had fallen more than once in a period that covered one month and another person had fallen from their bed having climbed over the bed rails. The provider could not tell us what action had been taken, as they were unaware of the patterns that had occurred, due to the lack of an effective audit. This placed people at risk of harm and also meant that people had not been referred to a healthcare professional to minimise the risk going forward.

We saw that there had not been any audits to look at the daily checklists of care delivered by staff in comparison to care records and daily notes. We found a number of discrepancies in three of the four records we viewed all for the week commencing the 4 July 2016, these were daily and weekly checks. These included omissions on the daily checklist where medicines should have been administered, yet the daily notes said they had been given. We observed on the day that staff signed the medicine administration records before the person had taken the medicines, so these too contradicted the daily checklist. This meant staff could

not be sure if a person had received medicines appropriately and the nominated individual could not easily check and audit for discrepancies and deal with issues if they arose.

Care records had not been audited by the provider, and therefore they had not been able to pick up that care records were not always completed thoroughly. We saw examples where formal reviews stated there were no changes in care plans, yet there had been a distinct change in a person's care requirements. Staff had also not been signing to say they had read care records and this had not been identified. This meant that staff did not have access to detailed up-to-date care records to support people that they cared for.

The provider had not formally assessed the dependency of the people living at the home on a regular basis. This meant that they could not accurately monitor when more staff were needed, or if they needed to reassess the deployment of staff. This meant that at times there were insufficient numbers of staff on duty to keep people safe or engaged in meaningful activities during the day.

Health and safety audits were out of date and staff did not know where emergency plans were kept, or when the fire alarm was tested. The nominated individual told us that there was no formal business continuity plan in place, or a risk register for the service. This meant that they did not have clear plans for the home, and had only informal, unwritten plans, meaning that overall service risk was not managed.

The provider did not have in place effective systems to monitor the quality of the service. The issues we found during our inspection had not been identified and therefore no action had been taken to improve the quality of care provided to people using the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they generally felt well supported. They told us that they felt they supported one another, one staff member told us, "Definitely feel supported by seniors, there are really nice staff here". Staff also said they could speak to the nominated individual if they needed to, but said that the nominated individual was only at the home a couple of days a week. This meant staff were unsure who managed the home on a daily basis, as the approach was in consistent. The nominated individual had approached some senior staff to see if they would 'act up' into a more senior role, but told us that these people did not want to do this.

Team meetings took place and staff did say they could raise concerns and most of the time these were listened too, or acted upon. For example one person had raised issues about staff members not supporting each other properly, and therefore they had agreed between them how better to informally communicate with one another. There was an agenda for the most recent staff team meeting; however this had not taken place due to staffing issues. Staff were unable to tell us what the home's statement of purpose outlined, with regard to the values, aims and objectives of the home. Staff were not always able to tell us, what people's care needs were and sometimes did not show consideration to people's feelings. Staff also delivered care in a way that was not always tailored individually and was task orientated. This suggested that they were not displaying the aims and objectives as laid out in the statement of purpose, whilst supporting people at the home.

Staff told us that they felt they had the confidence and the knowledge to speak out about any concerns they may have, outside of the current management team. They told us that they had access to a helpline they could call, or said they would speak to the local authority or the Care Quality Commission (CQC).

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Effective care planning was not in place to sufficiently ensure personal needs and preferences were met. People did not feel involved in their care planning. Regulation 9 (1) (2) (3) (a) (b) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Adherence to the Mental Capacity Act had not been undertaken, and decisions were not made using best interest discussions. People did not have appropriate and up-to-date capacity assessments that are in line with their individual needs. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk to people's safety had not always been assessed or action taken to mitigate these risks. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or

to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

Regulation 17 (1) (2) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not deployed effectively at all times to ensure that people's needs were consistently met. Regulation 18 (1)