Mr & Mrs A Cropley

Point House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Point House on 6 August 2014 and rated the home as Good. However, when we returned on 13 and 14 July 2017 we found some areas which required improvements to be made.

Point House is registered to provide care for up to 22 people. At the time of the inspection 20 people were living at the home. The home supports adults who have a range of different learning disabilities and mental health needs. Some people have lived at Point House for a long time and now have age related conditions. The accommodation comprised of a building over two floors.

There was a registered manager in place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. For the purposes of this report the registered manager will be referred to as the manager. On the days we visited the manager was not present but we spoke with the senior staff in charge.

At this inspection we found three breaches of the Health and Social Care Act 2008. You can see what action we asked the provider to take at the end of this report.

People's risk assessments were not always thorough enough and did not always include guidance for staff about how to mitigate the risks which some people faced. There were times when there was not a clear plan of action in place to manage these risks. People's weight levels were not consistently monitored by the service to identify when people were at potential risk of unintentional weight loss. There was no system or plan in place to ensure the manager and provider had an up to date oversight on this issue.

There was a system of safety checks but these were not always effective in identifying risks. We found certain house hold cleaning products were being stored in a way which was not safe.

We found that people did receive their medicines as prescribed. However, people's prescribed creams were not stored in a safe way in the home.

Staff had a full understanding about how to protect people against the potential for people to experience harm and abuse.

The staffing levels at the home were not always sufficient to meet people's social and care needs at certain points of the day. The layout of the building had not been considered as part of the deployment of staff.

Staff received regular training, which was refreshed each year. Staff said they felt supported by the manager and they received regular supervision. However, we found that some of the competency checks relating to staff practice were not well evidenced.

People's dietary needs were not always promoted and supported by the service. Staff did not spend time with people to promote healthy dietary alternatives. People who were at risk of poor health due to their relationship with food were not regularly supported to manage this issue. The service did not promote healthy alternatives or lifestyles. People were not fully involved in the cooking process in order to maximise their independence in this area.

Staff were gentle and kind with people, however the service and staff were not consistently caring towards people. We observed times when staff did not respond to a person who was distressed. Staff did not engage socially with people at the home. There were times the staff did not promote people's dignity. The service was not promoting independent living skills in the home.

There was a lack of social opportunities and experiences taking place in the home when people were present. Staff did not spend time chatting or engaging with people. The service did not explore potential social opportunities and situations in the home.

Quality monitoring audits of the service were not always effective. There was no monitoring of the culture of the service, and whether the service was fully promoting opportunities for people and meeting their needs.

The provider was not completing internal independent audits to enable the service to improve and develop. There were times when the manager was not present and there was no one person with an overarching knowledge of the home.

People and staff spoke positively about the manager, they found the manager approachable, and had confidence in their leadership of the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Improvements were needed to ensure the service was always safe.

Robust recruitment systems and checks were not fully in place.

Certain prescribed medicines and domestic products were not stored
safely.

The risks which people faced were not always fully explored and documented.

Staff had a good understanding about how to protect people from harm.

Is the service effective?

Requires Improvement

The service was not always effective.

People's dietary needs were not promoted by the service.

Staff competency was not always evidenced and checked.

Staff had inductions, received regular training, and felt supported.

Is the service caring?

Requires Improvement

The service was not consistently caring towards people.

People's dignity was not always promoted.

Practical action was not always taken to relieve distress.

People's independence was not promoted by the service.

People were treated in a gentle and kind way by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

There was a lack of social opportunities for people when they were in the home.

People's needs were not being fully reviewed or captured in their assessments.

There were planned outings arranged by the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

Robust audits and quality monitoring checks were either not taking place or not evidenced to show that they had taken place.

There was no independent quality monitoring taking place by the provider.

People and staff spoke positively about the manager.

Point House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned 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.

The inspection took place on 13 and 14 July 2017 and was unannounced. The inspection was carried out by one inspector and an Expert by Experience. An expert by experience is a person who has experience of this type of care service.

Before the inspection we viewed all of the information we had about the service. The manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications the manager had sent us over the last year. Notifications are about important events the manager or provider must send us by law. We also contacted the local authority quality assurance team and local authority safeguarding team to ask for their views on the service.

During the inspection we spoke with seven people who used the service and three relatives. We spoke with three senior members of staff, two members of the care staff. We later spoke with the manager.

We looked at the care records of four people who used the service and the medicines administration records of five people. We also viewed records relating to the management of the service. These included risk assessments, reviews, three staff recruitment files, training records, audits, and safety records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection at Point house in August 2014 we found the service was good in terms of supporting people's safety. When we visited Point house in July 2017 we found elements of the service which were safe. However we also found some areas which required improvements to be made.

We identified some issues with the staffing levels. There were two members of staff on duty during the day and the office staff were a potential 'back up' if required. However, we observed a period of time during the early evening when one person's needs were not being met. One member of staff was making the evening meal while another member of staff was assisting people to get ready for bed. There was no office staff present to assist in this situation. We also noted at times during the day there was no staff presence in the communal areas when people were gathering. We were told that some people could become upset with one another and one person was not mobile and living with dementia.

The layout of the building had also not been considered to enable office staff to attend to people's needs. Office staff were based in a building in the garden and were not present or near the communal parts of the home.

The above concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative had told us that they had been concerned about staffing levels at night. As for some time only one member of staff was on duty. We were advised by staff and we saw records which confirmed that this had now changed. A 'sleep in' member of staff was now present to assist the member of staff on duty, if there was a need to. We concluded that the way the staffing levels had been calculated at certain times of the day, required reviewing, in order to meet everyone's needs.

We looked at four people's care records and found three out of the four people's risk assessments did not fully identify the risks they faced. Neither did they have a detailed plan in place to mitigate the risks. One person had diabetes but there was no detailed and clear plan regarding managing this need. Another person sometimes smoked in their room, although they had been asked not to. Staff told us how they monitored this but this was not identified as part of their risk assessment and there was no documented plan in place. Two of these people had risks related to maintaining a healthy weight. One of these people had not been weighed for seven months and they were at risk of losing weight and there was no detailed plan to address unplanned weight loss.

However, some risks which people faced had been explored in detail with information to guide staff about what they should do in order to minimise these risks. For example one person was at risk of choking, this risk had been identified and a plan of action was in place to manage this risk. Another person was at risk of developing a breakdown to their skin due to their continence needs and a plan was also in place to prevent this from happening.

We found records did not consistently provide enough detail to demonstrate the risk had been identified and that staff knew what actions to take when supporting certain individuals.

When we visited the home we found some people's prescribed creams were being stored in a warm cupboard where a water boiler was located. These products should not be stored over a certain temperature; otherwise the effectiveness of these products could be compromised. The temperature of this room was not being monitored. We also found in this room a range of domestic cleaning products were being stored. Two of these products should not have been stored over a certain temperature. This was contrary to health and safety guidelines. We asked a member of staff why these products were stored in this room and they said, "It was ease of access." We raised this with the manager, who later told us these products had all been removed and stored in the appropriate places.

During our visit we completed an audit of people's other prescribed medicines. We looked at a sample of five people's medicines and found that people had received these medicines as prescribed. We reviewed people's Medication Administration Records (MARs) and found these records were completed appropriately.

Some people administered their own medicines. We were told the processes staff went through to check that these individuals were taking their medicines as the prescriber had intended. However, when we looked at the care records of one of these people who self-medicated; these processes were not clearly documented. We also reviewed two people's medicine cabinets; we found that one person had a prescribed product which was out of date. Following a conversation with a member of staff we concluded this was an error from the pharmacy. However, this had not been discovered when this medicine was recently checked in by a member of staff.

The service could not evidence they were testing for the bacterium Legionella. This is a water born bacterial and can cause people to become unwell. We spoke with the manager about this who told us the steps staff take to prevent the build-up of lime scale and they advised us that their water supplies were checked yearly. However, it was not documented that Legionella was tested for. We later received confirmation that this test was to be carried out. We concluded that no one had come to harm as a result of this and the manager had put steps in place to ensure this safety test took place in the future.

We were shown records which demonstrated that various other safety checks were taking place on a regular basis. Various electrical items and gas safety checks were taking place. The manager had recently commissioned a fire specialist company to check the fire precautions which were in place were appropriate. Staff received training about what to do in the event of a fire. This training included teaching staff how to use fire extinguishing equipment. We were also shown records of the fire safety checks which were taking place on a regular basis. This included regular fire evacuation drills involving both staff and the people present at the home, at the time of the drill.

The service had an emergency contingency plan. This set out various plans to follow in the event of an emergency, which prevented the service from functioning. This included a plan to accommodate people short term if the building was not safe. Or if there was a sudden reduction in staff availability. However, this plan had not been fully reviewed and when we asked a senior member of staff what or where the contingency plan was, they did not know. They told us that in the event of an emergency that they would, "Find a solution." The manager had been previously absent from the service for over 28 days. So staff needed to know what the individual plans were in the event of particular emergencies. We concluded that the contingency plan was not robust. This was raised with the manager after the inspection who put a plan in place to address this issue.

Staff recruitment checks were not always robust. The service ensured that new staff had completed the Disclosure and Barring Service (DBS) checks. Staff had two references each. However, out of the three recruitment files we looked all three did not have full employment histories recorded with any gaps explained. Staff identities were being confirmed as part of the DBS application, but the service was not keeping a record of these confirmed identities on staff's personnel files. These safety checks are important to ensure that, staff working in the home are, suitable to work in a care environment and people are safe in their care.

People we spoke with who lived at Point House told us that they felt safe at the home and when they were around staff. One person said, "I feel safe all the time." Another person said, "They [staff] know where you're going and when you're going to be back. I feel really safe in this place." All the people we spoke with said if they felt anxious they would tell the staff on duty.

People were protected from the potential of experiencing harm and abuse. We spoke with three members of staff who told us how they would identify if a person was experiencing harm in some way. Staff also talked about people being withdrawn or different to how they would normally present, as a potential sign of experiencing harm. All these members of staff said they would approach the manager if they had concerns. Most staff were aware of outside agencies they could also report their concerns to, such as the out of hours social services team. The number of this team and the adult social services team was displayed in the staff office. However, we spoke with one member of staff who said they would look at the procedures if they needed to speak with someone from outside the home and pointed to a group of folders. We later checked there was no information relating to the local authority safeguarding team or safeguarding guidance in these folders. There was also no information available for people who lived in the home to access if they felt the need to raise a concern, outside of the home.

There were plans in place to maximise people's safety who often left the service during the day and night. People needed to tell a member of staff that they were going out and where they were going. We saw this taking place during our visit. Staff documented this and this was checked at handover when the next shift started. A member of staff showed us the handover book and we saw entries confirming this happened. There was up to date information about individuals so staff could alert the police if a person did not return to the home. Accidents and incidents were also managed in a safe way. We saw records which confirmed when people had had an injury action was taken, to try and prevent this from happening again.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in August 2014 the service was found to be good at providing effective care to people. However, at this inspection in July 2017 we found that improvements were required in some areas. This was to ensure effective care was given consistently to all people at the home.

We identified some issues with how people were supported with their food and drinks. We were told by staff that the food menu was changed every few months and people were asked what they wanted on the menu. We were told that people were encouraged to look on the notice board and make suggestions. However, this was not written in a format that everyone could understand. Nor was the food menu itself. People were not being asked at their monthly reviews about the food and drinks provided. We were also told that people were being asked at 'resident meetings' about the food menus, but we noted these meetings were not happening on a regular and frequent basis. People were not being involved in a meaningful way in the cooking process. Some people had told us that they were moving into more independent accommodation, independent cooking skills were not being explored in the home. We were present when the evening meal was being cooked. One member of staff was doing this, they had assistance from one person living at the home, but the member of staff was too busy cooking for everyone to make this a learning opportunity.

When we asked staff about the alternatives people could have if they chose they didn't want the main evening meal, the options were limited. We were told people would be offered macaroni cheese or an Irish stew. Both of these were tinned products. We saw one person being supported to eat the Irish stew, it looked very dry and the person was struggling to chew it.

Some people had difficult relationships with food. This meant that they struggled to maintain a healthy weight and could over eat. One person was at risk of developing diabetes and another person had diabetes. These people's care plans identified this issue but it did not give guidance to staff about how they promoted healthy eating for these individuals, in ways they could potentially engage with. When we observed the evening meal time, a member of staff was cooking cheese burgers and chips and people had been offered a tinned alternative. There was no attempt to offer healthy options. There was no information to promote this around the service. This was not discussed at people's reviews. Staff did not discuss the importance of this with people during the days we were at the home.

Alternatively, one person had a specialist need with eating and drinking. They were at risk of choking. We could see that a professional from a particular health team had been involved and given guidance, to prevent the risk of this person choking. We could see that this advice was being put into practice when staff supported this person to eat.

We were also told about one person who had recently chosen to lose weight in order to be a healthy weight. They had been supported to seek medical support for this and they attended a particular group to enable them to do this. We spoke with this person who told us the activities they did to be 'healthy.' From speaking with a senior member of staff and looking at this person's care records we could see the home had

supported this person to achieve this goal. A senior member of staff said they had noticed that this person had continued to lose weight which they thought was a concern. They said that they had spoken with this person and agreed a plan to ensure the person did not become too low in weight.

The people we spoke with were positive about the food and drinks the service provided. We asked one person what they thought about their evening meal, they put their thumb up and said, "Tastes nice, this is the dining room." We observed meals to be well spaced and people appeared to enjoy the food. When one person received their meals they expressed positive sounds and said "Oh good."

We concluded that improvements were required with elements of how people were supported to maintain a healthy diet and have greater choice with their food.

Staff received an induction of two weeks training when they first started in a care role at the home. Staff would shadow more experienced staff for a minimum of two weeks. A senior member of staff told us that the amount of shadow shifts were dependent on what new members of staff felt they needed. They said, "Everyone is different." New staff completed the care certificate this is a set of standards which outlines what good care looks like. As part of this training staff were checked they were competent in their work. New staff had a meeting with a senior member of staff after their first and second week. We were told this was an opportunity for new staff to ask further questions and highlight any issues they may have had with their new role. However, we were told that staff competency and knowledge in their work was not checked during this process or in their following supervisions throughout the year.

We were told by a senior member of staff that staff received spot checks. The staff we spoke with said they knew spot checks were carried out. However, the manager did not keep a written record of these spot checks and how often they were carried out. Staff were also not given feedback unless it was negative as a result of a spot check observation.

One member of staff's file showed they had had a series of conversations about their practice. They were subsequently receiving support to improve their competency in certain areas of their work. This shows that an issue with this member of staff's practice was identified and action was being taken to address this. However, we concluded that more regular evidenced competency checks were required.

The staff we spoke with all spoke positively about their induction, and training. We could see that staff received training for example in food hygiene, infection control, health and safety, moving and handling, first aid, administration of medication and the safe storage of cleaning products. The training was delivered in the format of DVD training followed by a test and sometimes there was face to face practical training. The written 'tests' were marked by the company who produced this training for the home. A senior member of staff checked and monitored staff had passed.

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 so that they can 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.

The staff we spoke with told us how they offered choice and sought people's consent. Staff told us about the importance of people making their own choices with their day to day needs. We spoke with one member of staff who explained the process if a person lacked capacity to ensure that a particular decision was made, in their best interest. We looked at one persons' care record and we could see that the manager had made a best interest decision for this person. The manager had consulted with the person's known professionals and relatives in order to make a best interest decision on their behalf, about a particular decision.

People's freedoms were promoted and people moved freely about the local community. People were asked by staff to advise them when they were going out and when they should be returning to Point House. We observed people leave and return to the home either independently or in groups of two. Staff knowledge of DoLS was very limited and often incorrect. However, there was no one person living at the home who was under a DoLS. People who potentially lacked capacity were supported to go out on trips and did not express signs that they wanted to leave the home.

We therefore concluded that the staff and the manager were compliant with the MCA.

People told us that they were supported to access health professionals when they needed this support. One person said, "I see the Doctor when they take me, they take me down there, they do all that for me." Another person said, "Staff take me to the Doctor." We saw many examples of the people accessing the GP, opticians, and specialist health professionals when we looked at a sample of people's care records.

Requires Improvement

Is the service caring?

Our findings

Point house was previously found to be good in caring when we visited the home in August 2014. At this inspection we found some issues with staff practice which required improvements to be made.

Staff did not always respond to a person's continence needs when they experienced an incontinence episode. We noted that on two occasions a person had been sitting on a very wet cushion. Staff did not take practical action when this person presented as distressed in the early evening. Staff did not engage with people in a social way throughout the day. People appeared to walk about the home without purpose. The service and staff did not make efforts to engage with people on a social level. People were not being supported to be involved with their food and drinks. People who had health needs related to their diet and lifestyle were not supported or encouraged to make different decisions. As a result of these issues we could not conclude the service was consistently caring.

During our visit we observed some gentle and kind interactions from staff towards people. One person had brought a particular hair product, we saw a member of staff giving them advice about this. This was a gentle interaction. We saw a member of staff talking to a person whose birthday it was that day, talking to them about the card; they had received from their relative. However, the service itself had made no effort to mark this person's birthday. During our visit we did observe a lack of interactions between staff and people at the home. Often staff were not present with people in the communal areas.

The people we spoke with who we could communicate with felt they were involved in the planning of their care and they felt listened to. Two people were aware they could approach other professionals involved in their care if they needed to. However, there was a lack of advocacy information around the home, written in ways which everyone would understand.

People's confidential personal information and their care records were stored securely in the home. We also saw that people's rooms were private personal spaces. We observed that most people had their own keys and chose when they wanted to spend time in their rooms or in the communal spaces. Staff told us how they promoted people's dignity when they were supporting people with their personal care. This involved staff leaving the room at times to give people privacy during elements of their personal care routines.

However, we did note in two people's care assessments a reference to two people's continence needs. This was not expressed in a respectful way at times. In the early evening when one member of staff was supporting people with their personal care needs, this appeared rushed at times. During this process the member of staff turned to us and said, "We are doing teeth now." This was not very respectful to the adults who lived at the home.

People accessed the community independently. We saw that some people completed some basic domestic tasks. There was a kitchenette where we saw people making hot drinks for themselves and they helped themselves to cereals in the mornings. However, the service was not supporting people to be as independent as possible. They were not involving people with the meal menus, preparation, or shopping for

their food.

As a result of these issues we concluded that the service and staff practice was not consistently caring toward people at the home.

The people we spoke with were all complimentary about the staff and the manager. One person said, "I love [name of manager and member of staff]." Another person told us, "I wouldn't be anywhere else."

The relatives of the people who lived at Point House told us that they felt free to visit whenever they wanted to. One relative said, "They [staff and people] always say hello, we sit in the dining room."

Requires Improvement

Is the service responsive?

Our findings

When we visited Point House in 2014 we found that the service was good in how it responded to people's needs. However, we found some areas which required improvements to be made when we visited in July 2017.

People were not having meaningful reviews which fully involved them. People's assessments, care plans, and reviews were not written in a way the individual could access. When people had reviews these were completed and then read to the person, and they signed to say this had happened. From looking at these reviews it was unclear if people had been fully involved and asked their views about the care and support they received. People's mental capacity was not reviewed alongside their other care needs. Two people's records stated that they did not have the capacity to make financial decisions. However, this decision in both of these cases had not been reviewed since 2013. Whether their capacity to make other decisions had also changed had not been explored at their review.

During our two day visit at Point House we observed during our two day visit that there was no social stimulation for people and a lack of conversations and engagement from staff with the people at the home. We noted people sitting alone not engaging with people or staff. People did go out during the day often to the local shops. However, most people spent time moving around the home and into different communal spaces. Two people said they felt bored. Staff did not spend time chatting or engaging with people, staff supported people with tasks or were not present when people were in the communal spaces. The service was not utilising potential social opportunities to engage with people. On the day we visited it was a person's birthday, this was not explored in any real way by the service.

At lunch time a member of staff was present while people sat and had their lunch or watched a film. This member of staff was on their own lunch break and was looking at their phone. There was no engagement with people and most sat in isolation from one another. There was no attempt to make this or other parts of the day a social experience.

People did access educational courses, day services, and some voluntary work. However these were arranged and commissioned by social services. The manager and staff had not considered other ways to engage with people when they were at the home. There was a variety of games and activity tasks available but these were not accessed by people during the two days we visited the home. Staff did not spend time trying to engage with people or motivate them to take part in social activities. Staff asked people if they were ok as they passed them but they did not try and engage with them. There was no social atmosphere to the home. People sometimes presented as bored and without purpose.

From speaking with staff and looking at the notice board we could see there were planned trips which involved some people. We were told that people go to the local theatre at Christmas time. There had been a planned trip with five people who went to Lowestoft recently, and a group of people were going to a farm to make sausages the second day of our visit. We were told by staff that generally planned trips took place

monthly.

We concluded that the service was making efforts to provide local outings, but they had not considered ways to offer people social experiences and enable friendships to develop within the service, when people were at the home.

During the first day we visited the home we observed staff not responding to a person's needs who had dementia. On two occasions it was apparent that this person had experienced episodes of incontinence. Their care plan stated that they should be being checked if toileting assistance was needed. This was not happening, on two occasions the cushion they were sitting on was very wet. This person was also at risk of developing a breakdown to their skin. Early in the evening this person expressed wishes to leave the room and their chair, when no staff provided this support they became upset. As only one member of staff was available and supporting others this person's needs were not being met. We observed them becoming distressed before a member of staff reacted. We raised this with the manager who later told us that people's routines at this point of the evening will be reviewed. However, it remained unclear if this is what people wanted. Also, if people wanted support at this time, could the existing levels of staff, respond to these people's needs.

The above concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we looked at people's care assessments we found that these were person centred. Out of the sample we looked we found there was information about people's likes and dislikes. Their routines and how they wanted to be treated by staff and what was important to them as individuals. How people wanted to receive personal care was also explained in people's assessments. What people liked to do and what they took enjoyment from was also identified. However, the assessments did not explore what people's aspirations in life were with a plan to try and achieve this.

Two people who lived in Point House had formed a relationship with one another and hoped to move into their own tenancy in the future. We spoke with these people who told us how the staff and the manager supported them to develop their relationship further in a safe way. However, they did say they would like to spend more time together.

The people we spoke with said they would go to a member of staff to make a complaint. One person said, "Tell the staff." Another person stated, "Go to staff." A further person told us that they would, "Go and see one of the care staff, and then [name of senior member of staff, and name of manager]." However, ways to make a complaint in and outside the home were not explored or promoted about the service.

We spoke with one relative who told us that they had made a formal complaint. They said that they felt there had been a thorough investigation and they were advised about the outcome. The service had not received any other complaints since this time, but the relatives we spoke with were confident that any issues which they had, would be handled appropriately by the manager.

Requires Improvement

Is the service well-led?

Our findings

When we visited the home in 2014 we found that the service was being well led. However, following this recent visit in July 2017, we found areas which required improvements to be made, which were connected to how the service was run.

We found that there was a lack of activities and social interactions between people and staff at the home. Staff did not spend time chatting or engaging with people. Often there was no staff presence for people to engage with. People moved about the home at times without purpose and two people said they were bored. The atmosphere or culture of the home was not reviewed or assessed by the manager. When people were in the home there was no social atmosphere or social opportunities for people to engage with. This had not been identified by the manager or provider of the service. The service had not tried to engage with people and motivate them socially. When we spoke with people they appeared motivated to chat to us. When we left people asked us if we would be returning.

The meal experience had not been reviewed or monitored. People sat in isolation and staff did not play a role to make this a potential social experience if people wanted to engage with this. People were not being supported to have access to a healthy diet. The service was not promoting this in providing alternative healthier meals. Staff were not involving people with the meal choices and cooking of meals, in a regular and meaningful way.

There was not enough staff at times to meet people's social needs. We found there was not enough staff at one point of the evening to meet one person's care needs when they required this support. Staff were not putting the plan into action for this person. The layout of the building in terms of accessing additional staff when this was needed had not been considered. The manager and provider had not discovered these issues.

People's care assessments did not always fully explore the risks which people faced. Further information was needed to demonstrate the risks had been identified and a plan of action was in place to manage these risks. People's care assessments and plans were being audited but the audits had not identified these issues. Information relevant to people like their care plans reviews and assessments were not available in accessible ways for individuals. This issue had also not been identified by the manager or provider.

We found issues with how some people's prescribed creams were stored and how cleaning products were stored when we visited the home. The audits which were taking place for people's medicines did not evidence the checks which a senior member of staff said they were completing, to ensure people received their medicines safely and as prescribed. There was no system to ensure people's weights were being monitored, and in a way which would demonstrate if a person was under their recommended weight. Safety checks in relation to the recruitment of staff were not always robust. The service was not evidencing they were testing for Legionella or checking staff competency in a consistent robust way.

When we visited the manager was absent from the home and had been previously for a period of time.

Senior staff all had certain responsibilities, but there was no one person in charge who had an overall knowledge and understanding of all the responsibilities and where to access this information. During the manager's absence a person had experienced an overdose of their medicine but the senior in charge had not informed the local authority about this. They had been guided by the GP.

We raised these issues with the manager after our inspection. The manager told us that action would be taken to address some of the issues we found. However, in some cases they did not complete an investigation and then monitor what staff were doing. This was not a meaningful response with a plan of action to make improvements or to monitor these issues for the future.

The provider was not completing any separate quality audits of the home to provide an independent review of the service to enable the home to improve.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found that there was no partnership working with other organisations relevant to the people the home was supporting or community involvement with the service.

The staff we spoke with were positive about the service and were open to suggestions and issues when we raised them. Staff and people at the home spoke positively about the manager. Everyone said they found the manager approachable, and staff believed the manager placed people's needs first at the home.

From the records which we hold about the service the manager was notifying us of the important events they must notify us about by law.

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 Regulation 9 HSCA 2008 (RA) Regulations 2014: Person Centred Care The provider of the service did not have effective systems and processes in place to monitor and improve the safety of the service provided. Regulation 9 (1) (3) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The provider of the service did not have effective systems and processes in place to monitor and improve the safety of the service provided. Regulation 17 (2) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (RA) Regulations 2014: Staffing The management of the service had failed to have sufficient numbers of staff. Staffing.

Regulation 18 (1).