Wilbraham Limited

Wilbraham House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We completed an unannounced inspection at Wilbraham House on 16 September 2016. At the last inspection on 10 March 2015, we found that the service was meeting the regulations.

Wilbraham House are registered to provide accommodation with personal care for up to 33 people. People who use the service may have physical disabilities and/or mental health needs such as dementia. At the time of the inspection the service supported 32 people.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There was a registered manager at the service. 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.

At this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Risks to people's health and wellbeing were not consistently identified, managed or followed by staff safely.

We found there were not enough staff available to deliver people's planned care or to keep people safe.

We found that medicines were not administered in a consistent and safe manner and they were not always administered as prescribed.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not identified and rectified by the manager and provider.

Systems in place to monitor accidents and incidents were not being followed or managed to reduce the risk of further occurrences.

People did not always get the support they needed to eat sufficient amounts. Staff were not always available to monitor people were eating sufficient amounts. This meant some people's nutritional needs were not met.

Staff told us they received training. However, we found that some of the training they had received was not effective. There were no systems in place to ensure that staff understood and were competent to support people safely and effectively.

Advice was sought from health and social care professionals when people were unwell. However, we saw that people were not always referred to specialist health professionals to ensure their health needs were met effectively.

People told us they were treated with care and given choices. However, we saw that improvements were needed to ensure staff were available to provide care in an unrushed way that made people feel cared for.

People were not always treated with respect in an environment that protected their privacy and dignity.

Improvements were needed to ensure that people were able to access hobbies and interests that were important to them. We found that improvements were needed to ensure that staff were available to support people with hobbies and interests when the dedicated activities worker was unavailable.

People's care records did not contain an up to date and accurate record of people's individual needs. This meant that people were at risk of receiving inconsistent care.

People were protected from the risks of abuse because staff understood how to recognise and report possible abuse.

When people did not have the ability to make decisions about their care, the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were followed. These requirements ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

People knew how to complain about their care and the provider had a complaints policy available for people and their relatives.

People and staff told us that the registered manager was approachable and staff felt supported to carry out their role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from the risk of harm because their risks were not planned, managed or monitored to keep them safe.

Medicines were not administered and managed safely.

There were not enough staff available to consistently meet people's needs.

Staff understood how to protect people from abuse and their responsibilities to report potential abuse.

Is the service effective?

Inadequate

The service was not effective.

Improvements were needed to ensure staff were competent to carry out their role and training received was being followed correctly.

People were not always supported effectively with their nutritional risks. Health professionals' advice was not always sought to ensure people received effective care.

People were supported in line with the Mental Capacity Act 2005 and staff followed the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were caring, however we found that people did not always receive care that was caring because staff were rushed and did not have time to provide support that met their emotional needs.

Improvements were needed to ensure that people were consistently supported in a dignified way.

People's choices were respected by staff. However

improvements were needed to ensure people who had difficulty making choices were supported in a way that met their needs.

Is the service responsive?

Requires Improvement 

The service was not consistently responsive.

People were not consistently supported to access hobbies and interests that were important to them.

People were at risk of inconsistent care because care records did not reflect an accurate account of people's needs. Reviews of people's care were not always undertaken when people's needs had changed.

People knew how to complain and complaints were handled in line with the provider's policy.

Is the service well-led?

Inadequate 

The service was not well led.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not identified and rectified by the manager and provider.

Systems in place to monitor accidents and incidents were not being followed or managed to reduce the risk of further occurrences.

People and staff felt that the registered manager was approachable.

Wilbraham 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 was 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 took place on 16 September 2016, and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, the provider 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 the PIR and other information we held about the service. This included notifications about events that had happened at the service, which the provider was required to send us by law. For example, serious injuries, safeguarding concerns and deaths that had occurred at the service.

We spoke with four people who used the service, two relatives, three staff, the deputy manager and the registered manager. We observed how staff supported people throughout the day and how staff interacted with people who used the service.

We viewed six records about people's care and seven people's medicine records. We also viewed records that showed how the service was managed, which included quality assurance records, seven staff recruitment and training records.

Inadequate

Is the service safe?

Our findings

We found that people's risks were not managed or mitigated to keep them safe. For example; we saw one person being assisted to move by staff in an unsafe way on three occasions. We saw that this person was unable to stand independently and staff used inappropriate methods to assist the person to stand such as, lifting the person under their arms. Staff were aware that the person was having difficulty standing as the person attempted to sit down in the middle of the transfers, which was unsafe because the person could have fallen. The mobility care plan we viewed stated that staff needed to support the person with a hoist and sling if they were unable to transfer safely using their frame. The risk assessment we viewed was contradictory and stated that staff needed to use a hoist to safely transfer the person at all times. Staff we spoke with gave inconsistent accounts of the support that the person needed to move safely. All the staff told us that this person was transferred using their frame or handling belt and would only use the hoist occasionally if they were unable to support the person using their frame or handling belt. We saw staff attempting to pull the person out of their chair with the handling belt, which moved under the person. This was an unsafe way of using the handling belt and the person was at risk of harm. During our observations we did not see the staff consider using the hoist and sling to ensure the person was transferred safely. We spoke with the registered manager who told us that staff should use the hoist at all times and was unaware that they were not supporting this person safely. However, we saw the registered manager in the area at the time of the unsafe transfer who sis not raise any concerns with the way the staff were attempting the transfer. This meant that this person was at risk of harm because their risks were not managed or mitigated to keep them safe.

We saw one person had been visited by a physiotherapist to assess their walking. The physiotherapist's notes showed they had recommended that staff needed to prompt and encourage this person to use their walking stick to keep them safe as they often forgot. We saw this person left the dining area without their stick and staff did not encourage or remind them they needed their walking stick to keep them safe. Staff we spoke with told us they needed to ensure this person had their walking stick because they were unsteady on their feet. The care plans and risk assessments we viewed had not been updated to give guidance for staff to follow to ensure this person was protected from the risk of falls when mobilising. This meant that this person's risks were not managed and mitigated to protect them from harm.

We found that environmental risks had not been assessed to protect people from the risk of harm. For example; we saw that the stairs were open to all people within the service. One person's risk assessment stated that they could not use the stairs and they were at risk of falls due to their confusion. There were no details in the risk assessment to give staff guidance on how to keep this person safe when they were in the area of the stairs. We saw this person walked around the service throughout the day of the inspection and had access to the stairs. We asked the registered manager if they had carried out a risk assessment on the stairs to ensure people were protected from potential harm. We were told that they had not considered this and a risk assessment was not in place. This meant that people were at risk of harm because environmental risks had not been assessed or managed.

We found that medicines were not managed in a safe way. We found there were no 'as required' (PRN)

protocols in place to give staff guidance on when people should be supported with their PRN medicines. For example; one person's care records we viewed stated that staff needed to offer PRN medicine when they displayed behaviour that may challenge. We looked at their medicine records and we found there was not a PRN protocol in place to help staff to identify when the medicine was required and ensure that this medicine was provided consistently and at a time when the person needed it. The deputy manager who administered medicines was aware of this person's PRN medicine, but the care staff we spoke with were not aware that this person needed PRN medicine when they became anxious. This meant that there was a risk that this person would not receive their medicine to alleviate their anxiety when they needed it, which may but the person and other people using the service at risk of harm.

We found that medicines were not always being administered at prescribed. For example; we saw one person was administered their medicine at 11.30a.m. The Medicine Administration Records (MARs) we viewed showed that this medicine needed a four hour gap between doses. At 2.30p.m we saw the deputy manager prepare to administer the next dose of this person's medicine, which meant that there had only been three hours between doses instead of four hours as prescribed. We stopped the deputy manager before they administered the medicine and asked if they thought it was safe to administer this medicine. We were told that they thought it was okay because this person had only had one tablet at 11.30a.m, so they could have it earlier. The deputy manager did not administer the PRN after we had intervened and administered this after the correct amount of time had passed. This meant this person was at risk of receiving their medicine unsafely.

We checked the balance of medicine stock that the home held against the balance recorded on the MARs for six people. We found that the stock did not balance and there was more medicine than there should have been for three people. This meant that we could not be assured that these people had received the medicines they needed. We asked staff why the stock did not balance and they were unable to give an explanation for this and were not able to identify if these people had received their medicine as prescribed.

The above evidence shows that people's risks were not planned, monitored or mitigated in a way that kept them safe from harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people and relatives we spoke with about the staffing levels at the service. One person said, "I think there is enough staff, but I do a lot for myself so I don't need much help at all". A relative said, "There could be more of a staff presence with a role of offering and encouraging drinks and just to chat to people".

We saw there were not enough available to support people with their assessed needs at a time they needed it. For example; we heard one person calling out for assistance in the dining room. There we no staff available to help this person and we saw that this person was distressed. They told us that that they couldn't breathe. The inspectors had to find a member of staff to support this person with their needs. The registered manager found a staff member to help, who then supported this person with their inhaler to help them breathe. The person told us they felt better after having their medicine. This meant that this person was not supported with their anxiety and was not provided their medicine in a timely manner because there were not enough staff available at a time when they need it.

We saw there were not enough staff available to support people during mealtimes. We saw some people had to for a period of 45 minutes for their meals at lunch and were asking where their meals were. We saw that staff were rushed and there were long periods where there were no staff available in the dining areas. We saw and heard one person was calling out for more food, but there were no staff available to help them

or provide them with more food. This person left the dining area to find staff, but got distracted by another person who used the service. When staff arrived and asked what the person needed they person had forgotten what they wanted. We saw another person passing their food to another person because they did not want it. Staff were not aware this had happened and did not know that this person had not eaten their food because they were not available to monitor the dining area. The care records we viewed for two people showed that they needed constant monitoring and prompting to ensure they ate sufficient amounts. We saw that these people did not receive constant monitoring and they experienced difficulties eating their meal. This meant there were not enough staff available to monitor and provide support to people at a time when they needed it.

We found that there were not always enough staff available to support people in a responsive and caring way. We saw staff were rushed when providing support and were unable to give people time when they were upset or anxious. For example; one person became upset and a member of staff asked if they were okay and offered them a cup of tea. The staff member did not spend time sitting with the person as described in their care plan and did not return to check if the person was feeling better or had the cup of tea they had been offered. Staff told us that they were rushed and did not have time to spend with people. One member of staff said, "I'd like to give more people time, I do care about people but we don't have time to show it". This meant that there were not enough staff available to give service users enough time and patience to meet their needs in a caring way.

We viewed the incidents and accidents at the service for the period of a month, which showed that 12 incidents had occurred between the hours of 10.00pm and 7.00am. We saw from the staff rotas that the staffing levels reduced to two staff between the hours of 10.00pm and 7.00am. The incidents we viewed showed that one person who was at risk of falls had fallen on three occasions and there was a risk that staff would not be available to provide support to people when they needed it. For example; one person has a sensor mat in place to alert staff they were mobilising and there is a risk staff would not be available to support them to remain safe if they were supporting another person with their care needs, because their were only two members of staff available to support 32 people. This meant there was a risk that people would not receive the support they needed when they needed it.

We discussed our concerns regarding the staffing levels with the registered manager who told us that they had raised concerns about the staffing levels with the provider. They said, "I totally agree about the staffing, we can't give the time to people that they need", and "We can't provide activities when the dedicated member of staff isn't here because we don't have time. The activity co-ordinator has left us a plan, but we haven't been able to do it". The registered manager told us that they had discussed the night staffing levels with the provider and they had put an extra member of staff on duty between 7.00 am and 8.00a.m. We were not provided evidence of discussions between the registered manager and the provider regarding staffing levels at other times of the day and evening. The registered manager had not identified the trends in the incidents and that a number of these had occurred when the staffing reduced throughout the night. This meant that the shortfall in staffing had been identified but the action taken was not effective to ensure people received the support they needed when they needed it.

The above evidence shows that there were not enough staff available to meet people's needs and to keep people safe from the risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were protected from the risk of abuse because staff we spoke with understood how to recognise and report abuse. One staff member said, "I would not hesitate to report any concerns I had if I thought someone was not being treated right". We saw that staff had reported incidents to the registered

manager, who had taken action to ensure people were protected from the risk of abuse. The registered manager had a good understanding of their responsibilities to protect people from abuse and had reported incidents of abuse to the local authority for investigation.

Inadequate

Is the service effective?

Our findings

We saw staff using inappropriate methods of transferring a person on three occasions. We saw the person was supported by the two members of staff inappropriately under their arms because they were unable to stand independently. Staff told us and we saw that they had received training in manual handling practices. We asked the registered manager how they could be assured that staff understood how to mobilise people independently. We were told, "They [the staff] have had the training and which is refreshed yearly". We saw from the training records that some members of staff had not received their manual handling refresher training. We asked if there was a system in place to ensure that staff were competent after they had received training. We were told by the registered manager that there was not a system in place, although the registered manager told us they would correct staff if they saw inappropriate transfers. However, we saw the registered manager in the area at the time of the unsafe transfer who sis not raise any concerns with the way the staff were attempting the transfer. The registered manager had not identified the poor practice and taken action to ensure people were supported in line with guidance. This meant that staff were not always competent to carry out support to people in a safe and effective way and monitoring systems were not effective in identifying poor practice.

We viewed the training records for staff and found that there were large gaps where staff had not received training appropriate to their role. For example; we found concerns with the way staff were providing support to people who displayed challenging behaviour and we found that there were 15 members of staff who had not received training in how to manage people who displayed behaviour that challenged. We also found concerns with the way staff were supporting people with their nutritional needs. The training records showed that only one member of staff had received training in diet and nutrition. The registered manager had told us that staff had received this training, which showed that the system in place to monitor staff development needs was not effective.This meant that people were at risk of receiving inappropriate care because staff were not always sufficiently trained to carry out their support.

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

We saw people had mixed experiences during mealtimes. Most people were happy with the quality of the food and comments we received included; "The food is good here and if I want something different the staff are happy to do what I like" and "I have never had any problems with the food". However, we saw that some people had to wait long periods of time for their meals at lunch and were asking where their meals were. Staff were rushed and there were long periods of time where there were no staff available in the dining areas to support people with their assessed needs. For example; people were not supported to eat when they had been assessed as needing support from staff. One person needed prompting and encouragement to eat their meal as they became distracted at mealtimes. We saw that this person was not supported effectively and did not eat their meal, because there were no staff available to help them. Staff offered this person an alternative, which they started to eat but because staff were not available to prompt them they only ate a small amount before it was taken away. This meant that improvements were needed to ensure people received the support they needed at mealtimes.

People were not supported effectively with their nutritional needs. We viewed the weight records for three people which showed they had lost weight. One person had lost a significant amount of weight over a five month period. There had not been a change in their care plan or risk assessment to give staff guidance on the support required to prevent a further weight loss. There had been no referral to a dietician to seek advice or guidance on how to manage their nutritional risks. The care plan showed that this person required support to eat and drink sufficient amounts, but we saw that the support was inconsistent and rushed, which meant they were not provided with the support they needed. Staff we spoke with gave inconsistent accounts of the support they needed to ensure they ate and drank sufficient amounts, which meant the person was not supported in line with their assessed needs. We spoke with the registered manager about our concerns who told us they had spoken with the G.P about the weight losses, but they were unable to show us evidence of actions taken to lower the risk of malnutrition for these people. There were no food and fluid charts in place to ensure that these people's nutritional intake was monitored and managed to prevent further weight loss. This meant that people were at risk of harm because the provider had not put plans in place to ensure that people's nutritional risks were monitored and mitigated risks.

The above evidence shows that people's nutritional needs were not consistently met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were not always supported by staff consistently when they displayed behaviour that challenged. Care plans we viewed did not provide sufficient guidance for staff to follow to provide appropriate support when people displayed behaviour that challenged. For example; one person's care plan stated they were to be administered PRN medicine if they became aggressive or anxious, but did not give any guidance for staff to follow of how to provide low level support before using medicine to control their behaviour. Another person's care plan stated that staff needed to sit with the person and provide a cup of tea to alleviate their anxieties. Staff we spoke with gave inconsistent accounts of how these people needed to be supported, which did not always match the care plans. This meant that people received inconsistent and inappropriate care because people's care needs were not effectively planned or followed.

People told us that they were able to access health professionals when they needed to, such as doctors, chiropodists and opticians. However, we saw that advice was not always sought when people's health had deteriorated. For example; we saw that people had lost weight and there had not been a referral made to a dietician for advice to manage their nutritional needs. We also saw that when advice had been gained it was not always followed by staff. For example; we saw that one person had received advice from a physiotherapist about their mobility. The physiotherapist had advised that the person needed prompting to use their walking aid, but we saw that staff did not always follow this to keep the person safe from harm although they were aware that the person needed their walking aid to keep them safe. This meant that advice had not been sought or followed to maintain people's health, safety and wellbeing.

People told us that they consented to their care and staff asked their permission before they provided support. One person said, "Staff always ask me if it's okay before they help me". We observed staff talking with people in a patient manner and gained consent from people when they carried out support. Some people were unable to understand some decisions about their care and staff understood their responsibilities under the Mental Capacity Act 2005. 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. We saw mental capacity assessments had

been carried out when people lacked capacity to make certain, which contained details of how staff needed to support people in their best interests.

We saw that the registered manager had made referrals for a Deprivation of Liberty Safeguards (DoLS), where they felt people had restrictions in place to keep them safe. 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. Staff were aware of the restrictions in place and we saw staff support the people to keep them safe from harm in line with their individual DoLS.

Requires Improvement

Is the service caring?

Our findings

We saw staff interacted with people in a caring way although this was often rushed. We saw staff speaking with people face to face and using positive touch when they gave reassurance to people, but staff were not always able to spend time with people because they were busy. We saw people attempting to ask questions and chat with staff throughout the inspection, and the responses they received from staff were rushed. For example; one person was standing in the dining area and talking out loud about a family member and appeared confused and distressed. Staff saw this person and continued to walk past them without asking if they were okay or alleviating their concerns. Another person was upset and crying and a staff member asked them if they were okay and put their arm around them. This person responded well to this interaction, but the interaction was very short before the staff member left. This person became distressed again when they left the room, and continued to be upset alone and without support for a period of 20 minutes. Staff we spoke with told us they did not have enough time to give to people as they were very busy, which impacted on their care. This meant that people were not always supported in a caring way because staff did not always have enough time to spend with people to meet their emotional needs.

We found that people's dignity was not always considered. For example, one person was administered eye drops in the lounge area in front of visitors and other people who used the service. The staff member administering the eye drops did not ask this person if they wanted their eye drops to be administered in a private area, therefore, this did not promote their dignity. We saw another person entered the dining area with their jumper on back to front. Staff touched the person's collar as they walked past but did not inform them they had their top on the wrong way. This meant that people were not always supported in a way that protected their dignity.

People told us staff gave them choices in the way they received their care. One person said, "I am quite independent and staff let me choose what I want. I am always listened to". Another person said, "I can choose all sorts of things, like when I get up, the clothes I wear and where I sit (I like to sit in a certain place with my friends)". People told us and we saw that people were dressed individually and were given choices in the clothes that they preferred to wear. We saw people were given choices by staff throughout the day and staff listened to people's wishes. During lunch we saw that people who were able to communicate their choices were given choices of drinks and meals. However, some improvements were needed to ensure that people who had difficulty making choices were supported in a way that met their needs. For example; there were no pictorial menus available for people and staff had not considered helping people make choices by showing them the meal that was on offer.

Although we saw some undignified practices people told us they were happy with the way the staff supported them and staff were kind and caring. One person said, "They [the staff] are very kind and caring". Another person said, "The staff are friendly and are very sensitive when they are helping me to wash and dress". Relatives told us that the staff treated people in a kind way and they were happy with the way staff cared for their relative. One relative said, "The staff have been here a long time and they are kind and patient". People and relatives also told us that there were no restrictions on visitors and they were able to see their family and friends at any time.

Requires Improvement

Is the service responsive?

Our findings

People told us that there were some activities on offer such as; exercise to music, crosswords and watching films. However, we found that some people were not supported to maintain hobbies that they enjoyed before they lived at the service. For example; one person told us they used to enjoy stamp collecting, but they had not been supported to undertake this hobby. We found that this person's activity preference had not been identified or recorded in their care plans, which meant they were not supported to maintain an interest that was important to them. The provider employed an activity staff member who provided a varied activity programme for people to be involved in. However, the activity worker was not at the service on the day of the inspection and we saw people watching television, asleep in the lounge areas or walking around the service unsettled. We did not see that there were activities for people to keep them occupied or to maintain their emotional wellbeing. The registered manager told us this was because the activity worker was not available and although the activity worker had left a plan there were not enough staff available to carry out the activities on the day of the inspection. Staff told us that they tried to spend time with people but they were not always able to give them their time as they were busy supporting people with their personal care needs. This meant that improvements were needed to ensure that the provider had a contingency plan in place to enable people to access hobbies or interests when the designated staff member was not available.

We saw that some reviews were out of date and where people's needs had changed the records had not been updated to reflect this. For example; one person's mobility needs had changed and advice had been received from a health professional on how staff needed to support this person. We asked staff about this person who told us how they supported this person in line with the advice from the health professional. However, the care plans and risk assessments had not been updated and we saw that on one occasion this person was not supported in line with the advice received. This meant that this person was at risk of receiving inconsistent care because their records did not reflect the changes in their support needs.

We found that although staff knew people's care needs well, some improvements were needed to ensure an accurate record of how people were supported in a consistent way that met their individual needs. For example, staff told us how they needed to support a person who displayed behaviour that challenged. Staff gave inconsistent explanations of how this person needed to be supported in a way that met their individual needs. The records we viewed did not match what staff had told us. One staff member said, "Care records should tell us exactly what people need, but the ones here don't. We need to improve the care plans to show people's needs". This meant there was a risk that new staff working at the service who did not know people well, may not have the information they needed to support people in accordance with their individual needs and risks.

People and their relatives told us they knew how to complain. One person said, "I would speak to staff directly if I was unhappy". Another person said, "I have no complaints, but if I did I could tell the staff or the manager" A relative said, "I have no problem raising any concerns and the registered manager sorts them out straight away". The provider had a complaints policy in place and we saw that there was a system in place to log any complaints by the registered manager. The complaints we viewed had been acted on in line

with the provider's policy and a response had been sent to the complainant.

Inadequate

Is the service well-led?

Our findings

Risks to service users were not managed and monitored effectively. We found that there were some systems in place to monitor the quality of the service provided. However, we found that the systems were not effective and had not identified the concerns we raised on our inspection. For example; the registered manager showed us that weekly audits of the amounts of medicine in stock had been undertaken and a monthly medicine audit was in place. The areas of concern we had identified at inspection had not been picked up by the audits, which had been carried out by the deputy and signed off as correct by the registered manager. We informed the registered manager that the audit had not been effective in identifying the concerns with the management of medicines. The registered manager said, "I don't know what's happened, it's normally okay, we don't normally have any issues with medicines". The registered manager told us that they had recently had a pharmacy audit, and none of the areas we had identified had been identified by the pharmacy. We did not have a copy of this audit and we requested this to be forwarded to us by Monday 19 September 2016. We did not receive a copy of the audit from the registered manager. This meant that there was not an effective system in place to assess, monitor and improve the service and mitigate any risks to people associated with the management of medicines.

We found that people who were at risk of malnutrition did not have their food or fluid intake monitored. For example; one person had lost a significant amount of weight in five months. There had been no updates in their risk assessments and their food intake was not being monitored to ensure they received sufficient amounts to eat. We saw that the registered manager had a list of service users' monthly weights, but there were no details of the action taken where people had lost large amounts of weight in a short timescale. The registered manager had not identified the on going weight loss and what additional support people may need to maintain a healthy weight or whether there were any other underlying reasons for the weight loss. The registered manager told us they had spoken to the GP about this, but there was no evidence that people had been referred to other professionals to gain advice on how to manage their food and fluid intake effectively. This meant that there was not an effective system in place to monitor and mitigate people's nutritional risks.

We saw that incidents and accidents were audited monthly by the registered manager, but this was not effective. We saw that one person had fallen on three occasions and the audit did not show what action had been taken by the registered manager to ensure the risk of further falls had been lowered. The registered manager told us that the person now had a sensor mat in their room to alert staff when they were mobilising. We saw this was in place, but we found that care plans and risk assessments had not been reviewed or updated to show the change in this person's needs. The registered manager said, "I get what you are saying. I should have made sure that the actions are recorded, completed and up to date". This meant that the system in place to analyse and act on incidents and accidents was not effective.

We found there was not an effective system in place to ensure that staff were aware of their role and how they needed to support people. For example; the staff member in the kitchen was covering for sickness and there was no clear guidance for them to follow when preparing meals. We saw that one person who had lost weight was provided with a small plate of food at lunch time and they told us they were hungry. We asked

the staff member in the kitchen how they knew what size portions people should have and asked why this person was provided with a smaller plate. They told us they were covering for staff sickness and other staff had told them what people needed when they filled in the menu sheets. The menu sheets we viewed did not have any guidance to show individual portions sizes. We asked the staff and the registered manager why this person had been given a smaller portion and we were told, "This must have been a mistake as the permanent cook isn't in". The registered manager agreed that they needed clear guidance in place to ensure people were supported effectively. The registered manager implemented a template to be used to record people's nutritional needs on the day of the inspection, but we were unable to assess the sustainability of the new system.

We found that timely action had not been taken to change staffing levels to ensure people were kept safe and had their needs met in a timely way. We saw that there were not enough staff available and people were at risk of unsafe and inappropriate care. For example; we found there were not enough staff available to provide support to people who needed assistance and prompting to eat and medicines were not administered in a timely manner. We saw that staff were unable to provide unrushed and caring support to people that were anxious and needed their time. Staff told us and we saw that people were not supported with activities to promote their wellbeing. The registered manager told us that they had identified a shortage in staffing, which had been raised with the provider, but we did not see any evidence that this had been discussed or acted on. This meant that the registered manager had identified there were not enough staff available, but action had not been taken to meet people's needs and keep people safe from the risk of harm

We saw that accurate records had not been kept when people's needs had changed. We found that care plans and risk assessments contained different information about people's needs. The records did not contain sufficient up to date information and staff gave us inconsistent accounts of how they needed to support service users. For example; one person needed support to mobilise, we found that the care records and the risk assessments did not match and we saw that staff supported this service user in an unsafe way. Staff told us that the care plans did not contain enough detail to enable them to support service users effectively and in a way that they preferred. We asked the registered manager how they ensured that records were up to date and reflected the change in service users' needs. They said, "It's very difficult to keep the records up to date as the staff are very busy and don't always have time". The registered manger did not have a system in place to check that records contained up to date information for staff to follow. This meant people were at risk of inconsistent and inappropriate care because there were no systems in place to ensure that the care records contained an accurate record of people's current needs.

We found that records were not kept securely. We saw the cupboards where service users' records were kept were unlocked throughout the day and we also found service users' individual care notes and details of incidents had been left unsecured on top of the cabinet in the small lounge area. This meant that service users' confidentiality was not protected because their information was not secure.

The above evidence shows that effective systems were not in place to monitor, manage and mitigate risks to people and protect them from harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff we spoke with told us that the registered manager was approachable and they were available at the service on a daily basis. One person said, "I know who the manager is and they are always about if I need them". Another person said, "The manager is helpful and I could go to them if I needed to". Staff told us they received supervision on a regular basis. One staff member said, "Supervisions are a good opportunity to raise any concerns I might have". Another staff member said, "The registered manager is very fair and will address any concerns we raise". This meant that people and staff felt able to approach and raise

any concerns to the registered manager.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not supported effectively to meet their nutritional needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not planned, monitored or managed to protect people from harm or potential harm. Medicines were not managed in a way that protected people from the risks associated with medicines.

The enforcement action we took:

We served a warning notice to the provider telling them to make immediate improvements to the quality of care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to ensure that risks to people's health and wellbeing were assessed, monitored and managed effectively. The provider did not have effective systems in place to assess, monitor and improve the quality of care people received and accurate records of people's required care and treatment were not always kept.

The enforcement action we took:

We served a warning notice to the provider telling them to make immediate improvements to the quality of care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough suitably qualified staff available to support people with their needs at a time that they needed it.

The enforcement action we took:

We served a warning notice to the provider telling them to make immediate improvements to the quality of care.