A & R Care Limited

Barrington Lodge

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 28 and 29 October 2014 and was unannounced.

At our last inspection in November 2013 the provider met the regulations we inspected.

Barrington Lodge is registered to provide residential and nursing care for up to 44 older people, some of who are living with dementia. There are 12 places in the service for people requiring rehabilitation. This intermediate care service provides people with additional support on discharge from hospital, before returning home; or sometimes as an alternative to a hospital admission. Accommodation is arranged over three floors and there is passenger lift access. There were 43 people using the service at the time of our inspection.

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

Summary of findings

People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

Arrangements to obtain people's consent were not always in place. Where people were assessed as lacking capacity to make certain decisions there was little evidence that decisions were made in people's best interests in accordance with the Mental Capacity Act 2005 (MCA).

People using the service were not involved in day-to-day decisions about their care as much as they could be. People's needs had been assessed and basic care plans were developed. Care records identified how care should be delivered, but did not take account of people's individual preferences and social needs or interests. Information was not always available to people in a format which was meaningful to them and promoted choice.

There was little stimulation or activity for people using the service because there were not enough meaningful activities for them to participate in.

The arrangements for staff recruitment did not ensure that people using the service were protected from unsuitable staff.

Improvements were required to ensure the service was well-led. The registered manager and provider did not have effective quality assurance systems in place. They were unable to demonstrate how they identified where improvements were needed in the service. People had limited opportunities to share their views and comments on the quality of the service. The provider did not use information from people's complaints or feedback to improve the quality of the service.

People told us they felt safe living in the home and those staying for intermediate care felt the environment provided a homely setting for recuperating. Staff had training and knew how to recognise and respond to concerns about abuse and poor practice. The provider took action to assess and minimise risks to people's health and well-being.

People were supported to eat and drink enough to meet their nutrition and hydration needs. Care plans contained information about the health and social care support people needed and records showed they were supported to access other professionals when required. We saw that there was effective communication with other professionals and agencies to ensure people's care needs were met. Where people's needs changed, the provider responded and reviewed the care provided.

People were treated with kindness and patience. There were positive interactions and people were complimentary about the staff. Staff respected people's privacy and dignity and interacted with people in a caring and respectful manner.

We found breaches of the regulations in relation to consent, care planning and activities for people using the service, the support provided to staff, the management of complaints, the environment, the systems for monitoring the quality of service provision, staff recruitment and medicines management. You can see what action we told the provider to take at the back of the full version of this report. We have also made a recommendation about practice around mealtimes.

Summary of findings

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

Some aspects of the service were not safe. Processes and procedures for ensuring people received their medicines safely were not always followed.

Staff recruitment checks were not fully completed and therefore did not protect people from unsuitable staff.

People felt safe and staff knew about their responsibility to protect people from harm and abuse. Staff were aware of any risks and what they needed to do to make sure people were safe.

There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. Where people did not have capacity to make decisions about their care and treatment it was not always clear that the provider acted in their best interests. Not all staff understood the Deprivation of Liberty safeguards and the key requirements of the Mental Capacity Act 2005.

People received care from staff who were trained to meet their individual needs. However staff were not supported to deliver effective care as they did not receive regular supervision.

People were protected from the risks of poor nutrition and dehydration. People had a balanced diet although the arrangements for promoting meal choices needed improving.

People received the support they needed to maintain good health and wellbeing. The service worked well with health and social care professionals to identify and meet people's needs.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. People were positive about the care they received and felt respected. However, this was not supported by some of our observations because care was task orientated at times.

Staff were kind and attentive when supporting people. Staff knew the importance of treating people as individuals and maintaining their dignity when giving personal care.

Is the service responsive?

Inadequate

The service was not responsive. Care records did not sufficiently guide staff on people's current care, treatment and support needs. People's care plans and the care they received did not take into account their individual interests and social histories. These shortfalls put people at risk of inappropriate care.

Summary of findings

There was a lack of activities offered at the service with little to engage or stimulate people.

The provider did not have effective processes in place for dealing with complaints and responding to people's comments.

Is the service well-led?

Inadequate 

The service was not well-led. The provider did not have effective systems in place to monitor the quality of the service or to drive improvement.

There were few opportunities for people, their relatives and staff to be involved in or consulted about the way the service ran.

Where audits did take place, there was limited evidence that learning occurred as a result or how this was used to improve the service to people. There was no recorded analysis of accidents and incidents to check for themes or trends.

Barrington Lodge

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 checked 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.

Before the inspection we reviewed the information we held about the service. This included safeguarding alerts and outcomes, complaints, information from the local authority and notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

This inspection took place on 28 and 29 October 2014. The first day was unannounced and the inspection team consisted of three inspectors. The lead inspector returned to the home to look at records related to the management of the service.

We spoke with 20 people using the service, eight relatives, the registered manager and one other senior manager, eight members of staff, the chef and six visiting health and social care professionals. We observed care and support in communal areas, spoke with people in private and looked at the care records for 12 people. Not everyone at the service was able to communicate their views to us, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We checked three staff files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including health and safety records. We reviewed how the provider managed complaints and checked the quality of their service. We also checked how medicines were managed.

Following our inspection the manager sent us some information about staff training, complaints and quality assurance. We spoke with two people's relatives and three representatives from the Community Intermediate Care Service (CICS) team.

Requires Improvement

Is the service safe?

Our findings

People using the service did not raise any concerns about their medicines. However, we identified some concerns with the way medicines were managed. The service used two pharmacy suppliers, a local chemist for people staying for intermediate care and a pharmacy chain for those people staying long term. Staff told us they experienced some difficulty at times in ensuring prescription medicines were ready on time for people being discharged home. Health professionals also spoke of on-going issues with the GP service for people on the rehabilitation programme, especially in ensuring prescription medicines were correct. The nurse in charge told us they were working closely and coordinating with the GP practice to ensure medicine prescriptions were requested early and supplies were available in good time for people who were ready for discharge to avoid any delays.

We found inaccuracies on two medicines administration records (MAR) which showed that people had not been given some of their medicines as prescribed. For example, on one MAR a member of staff had hand written a list of medicines for one person, but not signed or dated it. This person was prescribed an antibiotic three times a day, but their MAR was unsigned for a whole day. The following day staff had recorded that the person refused their medicines. On another MAR staff had recorded a code 'N' for two days, but there was no corresponding definition.

The majority of people on the intermediate care programme were taking their own medicines, however, there was no assessment record in place to determine if they could safely self-administer them. Neither was there evidence maintained to confirm how staff monitored this effectively.

Medicines were not stored or disposed of safely. We found a used sheathed syringe in an unsealed bin in an unlocked treatment room during the first day of our inspection. This could have put people and those working in the service at risk of injury. We brought this to the attention of the registered manager who removed the bin and discarded it appropriately. Each bedroom had lockable storage facilities available, but these were not in use. Medicines used by individuals were stored in non-lockable drawers which could pose a risk to people.

A care file seen for one person included a form for administering covert medicines in the person's best interests but the correct process had not been followed. This document had been signed by the GP and included agreement from their relative in the form of an attached email. The form did not fully document the reasons for presuming mental incapacity and we were unable to see evidence that further reviews had taken place to make sure that the covert medicine was still needed. The agreement was dated 28/08/14 with a review date of four weeks. In addition, this person's medicines care plan had not been updated since May 2014 and the registered manager acknowledged that information about their prescribed medicines was incorrect as they had changed.

The above shortfalls were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Other aspects around medicines management were safe. We observed a member of staff giving people their medicines at lunchtime. The nurse followed safe administration practice and people were given time and the appropriate support needed to take their medicines. There were clear processes in place for the storage and administration of controlled drugs.

The recruitment and selection processes were not protecting people living in the home. When we checked personnel records for three newly recruited staff, we found that the appropriate checks were not completed prior to their appointment. Although there was confirmation of a criminal record check for the three staff members there was no employment history for one new member of staff and only one reference available. For another member of staff the reference was not stamped to confirm the authenticity of the referee and the person had worked previously in a registered care setting. This meant the provider did not have complete information to assess whether these staff members were suitable to work with people using the service. These shortfalls were a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People using the service said they felt safe living at Barrington Lodge. Individual feedback included "Yes I feel safe here, I'm glad I came here" and "I feel very safe here." They told us they felt safe living in the home and felt the

Requires Improvement

Is the service safe?

environment was a more homely setting for recuperating. A relative told us, "I've never seen anything of concern, the staff are not rude." However, we found two instances of unsafe practice as stated above.

There were processes and procedures in place to protect people from abuse and keep them free from harm. Staff were aware of their responsibilities to keep people safe and report any allegations of abuse or concerns about people's safety. One staff member told us, "Everything is reported here, I always go to my manager." Staff told us they had completed safeguarding training and this was refreshed regularly. The training list provided by the manager showed that safeguarding training was last held in September 2014.

Records held by CQC showed the service had made safeguarding referrals when this had been necessary and had responded appropriately to any allegation of abuse. Where safeguarding concerns had been raised, the provider had liaised with the local authority and other professionals to investigate events. This meant they had followed the correct procedures, including notifying us of their concerns.

There were risk assessments in place which set out what to do to keep people safe. Records of care and support showed suitable arrangements were put in place to manage these risks appropriately. For example, we saw that steps were taken to help people who were identified as at risk of falls or who had a history of falls mobilise safely. A person who had a brief spell in hospital due to orthopaedic surgery was discharged to the home so that they could rehabilitate successfully. The person told us they felt the environment was suitably adapted to their needs although the bedroom was small. They commented, "I feel more confident in the home environment as it is less busy than the hospital, I get the full attention of the specialists and am making good progress with my walking."

Five out of seven people we spoke with said there were enough staff around when they needed assistance. Comments included, "They have quite enough staff", "An awful lot of staff" and "Staff walk about quite a bit here, you can ask them to help you." One person said, "I do not worry about falling during the night since I came to live here. There are staff available to ensure I am cared for safely and I get the support I need to use the bathroom." However, two people told us that they had to wait for help at night and in the mornings saying, "You have to wait a long time in the morning, there is too much waiting" and "I do think they need more help at night, lots of buzzers going on." We brought this to the attention of the registered manager who agreed to check the response times to call bells and monitor these regularly.

Our observation showed that staff were always present in communal areas and responded quickly to people's needs and requests. The staff we spoke with said that there were enough staff on each shift, however, they would welcome more opportunities to spend time with people. One staff member told us, "Yes, enough staff generally. I would like to give more time to the residents."

There was a registered nurse on duty at all times to meet the needs of those people who needed nursing care. The manager told us they had recruited several new staff recently and there were no vacancies.

We found the home was well maintained which contributed to people's safety. Servicing and routine maintenance records were up to date and evidenced that equipment was regularly checked and safe for people to use. This included maintenance checks on wheelchair safety, the lift, hoists and adapted baths. Fire alarms and equipment were tested to ensure they were in working order. There was an emergency evacuation procedure for each person that identified the help they would need to safely leave the building in an emergency. Fire evacuation drills were held regularly involving both people using the service and staff. Staff regularly reviewed the water temperatures to ensure they were at a safe level.

People using the service told us that the home was kept clean and hygienic. Communal areas and bathrooms were clean, however, we noted a strong odour in a top floor bathroom. We also found doors to a treatment room where oxygen was stored and to the sluice room were unlocked. Both rooms were in need of repairs. A water leak had damaged a lockable cupboard used to store chemicals for cleaning and the cleaning items were not stored securely. The provider told us the sluice room was not in use and it was due to be refurbished. They also said there were plans to replace the bathroom flooring and other redecoration works were due to take place. When we returned on the second day a maintenance member of staff had started repairs in the treatment room. Both doors were locked.

Requires Improvement

Is the service effective?

Our findings

People using the service were positive about the skills and approach of the staff supporting them. One person told us, "The staff are very kind and very understanding" and another individual commented, "The staff are hardworking, helpful and pleasant." Despite people's positive comments we found shortfalls in the support provided to staff and the provider's understanding of legislation about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

We were unable to find evidence in staff files that staff had received regular supervision and annual appraisals. Staff told us that there had been a number of staff changes in the past 12 months, and that they had not had regular one to one supervision. The last recorded supervision for staff was held in February and March 2014. A senior nurse had joined the service in March 2014 and told us they would be taking on responsibility for staff supervision. They said they were planning supervision meetings with members of staff. Staff were not being provided with a formal support system to look at their individual practice and professional development. This meant there was a risk that poor practice or lack of knowledge would not always be addressed. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff understood the importance of gaining consent. Throughout our inspection staff always sought people's permission before carrying out any care or support. Assessments of mental capacity were being completed, however, these were not time or decision specific and lacked detail as to how staff were making judgements about the ability of the individual to understand, retain, use or communicate information. In addition there was no reference to how people communicated before deciding that they lacked capacity to make a decision.

A 'consent for care, treatment and support form' seen for one person using the service had been signed by them in 2012, however, there was no evidence of any further reviews taking place. The information provided to the person at that time stated that consent would be reviewed regularly with their care plan.

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA) and are in place to ensure people are looked after in a way which does not inappropriately restrict their freedom. The registered manager told us they had not needed to make any DoLS applications at the time of the inspection. Policies and guidance were available to staff about the legislation and the manager and senior nurse had completed relevant training. Other staff had not received training around the use of the MCA or DoLS. Staff were unaware of the impact of the recent Supreme Court judgement and did not know what processes to follow if someone was likely to be deprived of their liberty. One staff member told us, "People cannot go out alone, it's not safe." They said they would contact their line manager if someone tried to leave the service. We were not assured that staff understood and acted within the principles of the MCA 2005. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People spoke positively about the food, but reported there was no choice available. Comments included "The food is good. No choice, but it's all good", "They give you a good meal" and "The food is very good." A relative told us, "The food is very good, they eat extremely well."

Our observation of the lunchtime was that it was unhurried with staff providing appropriate support when required to help people eat and drink. However, we saw that people were served their meal plated with no choice given as to the food or quantities being provided. Everyone was served the same drink of orange squash. Condiments or sauces were not provided on tables and people were provided with bibs rather than napkins. It was noted that the television remained switched on in the lounge and the mealtime was quiet throughout with little social interaction observed.

The meal for the day was displayed on a whiteboard in the dining room, however, this could be difficult to read from a distance and there was no alternative option. The cook told us if people did not want the main meal offered, they could choose something else. Two people confirmed this. We noted that staff did not routinely give people information about what they were eating. Staff served the meals saying "Here is your lunch" or "your pudding". We asked a staff member what was being served for pudding and they had to go and check the whiteboard to find out. We sat with one person who refused to eat their dessert and told us they did not like it. An alternative was not offered until we intervened and asked for them.

Requires Improvement

Is the service effective?

People's food preferences were recorded in their eating and drinking care plans, but it was not clear how these were used to inform the menu planning. We asked the registered manager and chef to consider whether the menu format could be made more accessible to people, particularly those people living with dementia. They agreed to review this.

A Malnutrition Universal Screening Tool (MUST) was completed for each person to identify any risk around eating and drinking. Records of people's weights and the food and drink they had taken were maintained. Care plans contained information about the areas people needed support with and any associated risks. For example, where people had swallowing difficulties and needed a soft diet, the care plans explained how the person should be supported. We saw evidence that people's care plans were updated as their needs changed so that people had effective support to eat and drink enough to maintain their well-being.

The service provided appropriate food for people's diverse needs. The chef was familiar with people's dietary needs and their personal or cultural preferences. For example, Halal meat was available and the chef had information available about people's specific needs, including those requiring soft diets or diabetic foods.

People felt their health needs were met, they told us staff took prompt action when they were unwell and said they saw the GP as and when required. The lead nurse told us a number of GP practices were involved in providing healthcare for people in the home, but one practice provided the service for people on the rehabilitation programme. This helped staff better coordinate the service and make suitable discharge arrangements with the person's own GP.

One person we spoke with had an orthopaedic procedure undertaken at the hospital and came to the home two days later for their rehabilitation programme. They said, "The physiotherapist works through with me on the exercise programme. I find this home is a more suitable environment than hospital, staff give me the time needed to work through the regime." Health professionals told us about people who had achieved positive outcomes at the service, which had enabled individuals return to their homes after a brief period of rehabilitation. One visiting health professional commented on the progress made by a person who was rehabilitated successfully and discharged back to their own home with a comprehensive package of care.

However, despite positive outcomes experienced by people we found areas of the environment were unsuitable and not effectively meeting people's needs. A number of the bedrooms seen lacked suitable space for wheelchair users to mobilise independently. Lack of dedicated storage facilities meant that hoists and other equipment were being kept in bathrooms. We noted two instances where people using the service would not have been able to use the toilet due to the equipment stored there. Health professionals gave us examples of occasions that arose where persons were accommodated in unsuitable bedrooms, and essential equipment such as hoists could not be used. One health professional told us the provider had offered alternate vacant bedrooms when they were available to resolve these issues. The registered providers told us they planned to dedicate an area of Barrington Lodge for the intermediate care service. They explained that the 12 beds were spread over the three floors because some people staying for long term care did not want to move rooms. These issues were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us and records confirmed that they had received training and support to help them carry out their work role and support people's needs. A qualified staff member spoke about the specialised training they had attended to ensure their skills were up to date including catheter care and monitoring of blood sugars. Other training attended included medicines, safeguarding people from abuse, fire safety, stroke awareness, diabetes, dementia and palliative care.

We recommend that the provider refer to available best practice guidance around mealtimes from bodies such as the Social Care institute for Excellence (SCIE) or the Royal College of Nursing (RCN).

Requires Improvement

Is the service caring?

Our findings

Many people spoke positively about the care they received at Barrington Lodge. Our observations and information shared with us by visitors and healthcare professionals in the home indicated this was their experience too. Comments about the care provided included, "so kind and polite", "They treat the patients nicely here" and "The staff are very good here, they put up with a lot." One person told us, "Polite? Of course they are." Another person described staff as "dedicated."

Relatives told us that they were made to feel welcome by staff and we saw examples of staff greeting visitors, making them drinks and facilitating their visits to be more private. Visiting relatives comments included, "The staff are fine, its ok here" and "I think it's very good", "It's marvellous here" and "excellent care." Despite people's positive comments we found staff interactions were task focussed at times and care was not consistently person centred.

Our observation showed staff responded to people in a kind, caring and respectful manner and we saw examples of staff using touch to reassure people, holding their hands when they were upset. However, we did not see staff spending time sitting and talking with people. The majority of interactions between staff and people using the service were brief and task orientated and did not positively impact on people's wellbeing. For example, at lunch staff served people their meals but there was little engagement or conversation with those people who ate independently.

Staff did take time to explain the support they were providing with some care activities. When using a portable hoist, staff reassured the person by talking to them about the actions they were taking throughout the process. Staff operated the hoist in a careful and gentle manner so the person felt relaxed. However, we saw a new member of staff left alone with people using the service in the communal lounge on more than one occasion during our observation. They were seen to be attending to individuals as required but were observed to be unsure of people's names and how best to communicate with them. The manager later informed us that two staff had just started working in the home on the day of our first visit and were still getting to know people.

Records about people's care were not always centred on the person and their individual preferences. We saw a generic form in a folder that staff used to record whether people had a bath or shower. The format included a tick box and did not consider people's individual preferences for personal care. An example entry stated, "[name of person] must have shower every day or bath." We noted two instances where staff members described people using the service as 'feeders' referring to the support they required during mealtimes. We brought this to the registered manager's attention as the use of this labelling language did not uphold the individuality and dignity of people using the service.

Two bedrooms were not single occupancy. We spoke with two of the people who were sharing a bedroom and noted that screens were provided. However, people told us they felt their privacy was compromised as they were unable to have private discussions with relatives or staff without these being overheard. The provider told us they would review the shared room arrangements.

We noted people were involved in decisions about any moves between, in or out of services and their preferences and choices were respected. Appropriate referrals were made to other services such as domiciliary care services and to district nurses and these were arranged in good time for discharge.

Staff were positive about the care being provided. They said, "I'm happy with the care we provide here" and "It's a good place." They said that they would recommend the home to their friends and relatives.

Care records included details about people's ethnicity, preferred faith and culture. People were provided with cultural foods of their choice and supported to follow their chosen faith. Staff knew the importance of respecting people's diverse needs and choices. For example, one staff member explained they always asked a person their preferences for care and how they respected one person's choice for gender of staff. Another staff described how they would support a person with their religious beliefs and make sure they were allowed time for prayer.

We observed that individual staff knocked on people's doors and all doors were closed during the delivery of personal care. Staff were able to explain to us how to protect people's dignity when providing personal care.

Inadequate

Is the service responsive?

Our findings

People were not involved in their care planning as much as they could be. One person said they were aware of having a care plan but had not seen it. They asked a staff member if they could see it and the file was provided to them. Other people were not aware of their care plan or said they were not interested in seeing this document. The care plans we saw were not signed by the people using the service and there was no information recorded to show whether they had been involved with their development.

Care plans contained basic information which focused mainly on people's health care needs and provided little information about people's preferences or personal history. They were mainly task orientated and lacked personalisation. Sections for life story and lifestyle in each care file we looked at were blank and there was only brief information about individual backgrounds recorded in the admission assessment completed for each person. Plans for people living with dementia were generic and referred to staff 're-orientating them to time and place' and providing support 'in a calm way'. We did not see any detailed guidance for staff as to how to communicate effectively and engage positively with individuals.

People were at risk of receiving inappropriate care because their care needs were not always reviewed in a timely way and staff did not have accurate information about how to support their individual needs. There was no evidence that the daily notes kept by staff were being used to inform regular evaluations of each person's care plan. Recorded evaluations seen stated 'no change to care plan' with no further commentary added. We found two people's care plans had not been reviewed where their mobility needs had changed. Falls assessments had been completed on admission but not reviewed since June and August 2014. One person's assessment identified a high risk of falls but their care plan had not been updated to inform staff how to reduce the risk. The nurse told us they were in the process of reviewing all people's care records. We saw records to support this.

Care plans for people using the rehabilitation service were up to date although they also lacked personalisation about people's preferences. One person staying for intermediate care told us they had not been asked about their preferences since moving to the service. We saw from records each person had a series of risk assessments for the activities of daily living undertaken. These showed the benefits to the person of enabling them to retain and develop independent skills as well as the actions needed to minimise risk.

A health professional we spoke with after the inspection visit shared with us some concerns about the suitability of Barrington Lodge for the rehabilitation programme. They said they did not find it to be always as responsive as it could be due to the planning and assignment of care staff. They found the layout of the home did not consider the needs of people on the short rehabilitation programme as they were accommodated in bedrooms over various floors according to room vacancies that arose.

Staff were not allocated specifically to look after people on this programme, but also had responsibility for a number of other people, the majority of whom spent the daytime in the large lounge. We did not see a visible presence of staff attending to check on people on the Community Intermediate Care Service (CICS) programme. Two of the people told us they at times felt quite isolated in their rooms especially at weekends.

People were not provided with meaningful and stimulating activities to meet their needs and reduce the risk of social isolation. People told us that there were some activities on offer, but these did not happen very often. Four of the six people we spoke with felt that there could be more for them to do. One person told us, "We are left to our own devices. They do play skittles but I get a bit fed up with just that." Another individual remarked, "That is a problem, nothing at all going on." Other comments included, "Not much, it's a small quiet home" and "I sit here and watch TV." Four people's relatives told us they were not satisfied with the social activities provided at the service. One told us it was the first time they had seen staff play a ball game with their relative. One care record included recent feedback from a visiting professional noting the lack of a personal activity plan for their client incorporating their interests and hobbies.

Staff told us that they provided daily activity sessions such as skittles, ball games and painting people's nails. An external visitor also provided a structured activity session each Monday afternoon. There was no displayed information for people about the available activities.

The television was on in the communal lounge throughout the first day of our visit with two or three people watching

Is the service responsive?

this intermittently. We observed a new member of staff playing skittles with two people using the service in the afternoon of the first day of our inspection. Other people who remained in the communal lounge throughout the day were not involved in any activities. Activity care plans seen were not specific referring to individuals 'requiring activities for stimulation' or being 'very confused' and 'easily distracted'. There was a lack of any detailed information for staff as to people's interests and activities they may enjoy. Staff members we spoke with referred to activities as a potential area for improvement. Their comments included, "It would be good if they could do a little bit more" and "We need more activity." The registered providers told us they planned to increase the number of activities on offer.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We checked how the service worked together with the local CICS team in providing an intermediate care service. Nurses, therapists and generic support workers together with care home staff offered rehabilitation. This service provided interim support and rehabilitation for two weeks for people who were considered unsafe to remain at or return to their own homes temporarily. Each person had an assessment completed by an experienced NHS nurse before they were admitted. This helped ensure the home accepted people whose needs they felt confident they could meet. A person told us of the benefits of the rehabilitation programme they received in the two weeks since admission; this programme had helped them become more mobile and they were assessed and supplied with suitable walking aids and were ready to be discharged home with a suitable care package arranged.

People told us they felt able to raise any concerns or complaints should they have any. Their feedback included, "I told the manager about something and it was all sorted", "I would go and see the manager, she's in charge" and "I don't know who the manager is, I would go to see the girl at the desk." However, feedback from relatives/ representatives of people using the service was not so positive. Two of them told us they had raised a number of concerns with the registered manager, but that they did not hear back and did not have confidence that she listened or responded to their concerns. The manager told us concerns were often discussed and dealt with prior to them becoming formal complaints. They said two formal complaints had been received in the last 12 months, but there were no records available to show how these were dealt with and responded to. Following our inspection we were sent this information which showed that the complaints were investigated and resolved satisfactorily.

The complaints procedure was not accessible to people using the service and their relatives or representatives. It was not produced in an easy read format, for example using large print, pictures and plain English or displayed where people using the service and their representatives could see it. Two relatives told us they were not aware of the procedure. There was no comments or suggestions box to encourage people and visitors to share their views. The provider did not have effective processes in place for dealing with complaints and responding to people's comments. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

People using the service were not aware of any regular meetings taking place to involve them with the running of the service. We found that systems to seek the views and opinions of relatives, people living at the home and key stakeholders required development. Some of the relatives we spoke with commented on difficult communication between themselves and the registered manager. They felt they were not listened to.

The registered manager said they often received complimentary feedback from visitors. However, there were limited systems for obtaining and recording people's views about the service and using these views to develop and improve the service provided. There had been no residents' or relatives' meetings, and the most recent quality assurance forms from people and relatives were returned in 2013. The survey results were not available at our inspection, but sent to us after we requested them. The quality assurance findings from 2013 were brief and did not evidence that action had been taken to improve the service. For example, it was recorded that activities could be improved. At this inspection, we identified concerns that people were still not being provided with enough activities despite the fact it was highlighted in surveys 12 months earlier. The provider told us that a quality assurance survey for 2014 was underway although we found no evidence to support this.

The provider's systems to assess the quality of service were not effective as they did not always identify areas for development and improvement. When we asked to see records of quality assurance checks, the manager provided us with records of an infection control audit, completed cleaning schedules and a list of changes made to the premises in response to a fire safety audit. The provider told us they carried out regular audits and were at the service most days. However, there were no records of these visits available to show what was being checked or how they assessed the quality of care of people received. There was no action plan in place that would highlight any strengths and weaknesses in the service as well as planned improvements.

While accidents and incidents were reviewed and actions taken to reduce risk they were not analysed for possible trends over time which may also help to reduce re-occurrence. There was no system in place that analysed the outcomes of incidents and accidents in order to learn from these and to improve the quality of the service. For example, the manager had not reviewed accidents or incidents collectively to look for trends and themes such as falls.

There were limited systems in place for staff to discuss issues and influence the operation of the service. The last recorded staff meeting was held in April 2014. Staff files identified that formal supervision meetings had not taken place regularly. This meant systems were not in place to monitor staff development and make sure that staff were able to meet people's needs safely. Staff told us they were not provided with questionnaires to give their feedback. The provider did not have appropriate systems in place to record staff training. For example, training certificates were stored randomly within individual staff files or in a separate training folder, but there was no matrix to monitor the number of staff that had completed all the necessary training. The manager sent us information about training held over the last 12 months but there were no details about how many staff had attended. It was therefore not clear how the provider made sure staff were up to date with their skills and knowledge. Audits were not undertaken for staff recruitment or staff supervision.

All the issues above meant there was a lack of systems in place to check that people's needs were being met and that the service was operating effectively. The provider had also not identified the shortfalls we found during this inspection. The issues above relate to a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were some quality checks in place to ensure that people were safe and appropriate care was being provided. Staff had designated responsibilities to help audit and monitor service provision. These routine checks were undertaken weekly or monthly and looked at areas such as the environment and equipment, food safety, cleanliness and fire safety. Some improvements were underway. For example, the senior nurse told us they were in the process of checking that people's care documentation was complete and up to date.

Staff were positive about the way the service was run. One staff member described the manager as "quite friendly" and told us, "She will listen, it has improved here as the manager is more involved." Another staff member said

Inadequate

Is the service well-led?

there was “open management” and felt that the manager was supportive. Staff were aware of the whistleblowing procedures should they wish to raise any concerns about poor practice.

Staff felt there was good teamwork and there was on-going dialogue and information exchange about the needs of people using the service. As well as meetings, a communication book and daily handovers were used to support the sharing of information.

We attended a multidisciplinary team meeting between the home staff and the CICS team. We observed the team worked well together and placement reviews were held weekly with social services personnel and staff at the home. There was good communication facilitated between staff, individuals’ progress and discharge arrangements were discussed in depth at weekly meetings. This showed the provider worked in partnership with other professionals to ensure people received appropriate support to meet their needs.

The provider submitted notifications as required by the regulations. A notification provides details about important events which the service is required to send us by law. There was a registered manager in post, who was also one of the registered providers that owns the home. She was supported by a senior nurse, who had started in post in March 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment. Regulation 18 (1) (2)(e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines. Regulation 13.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person had not ensured that the specified information in schedule 3 of the regulations was available in respect of staff employed for the purposes of carrying out the regulated activity. Regulation 21(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure staff were adequately supported to deliver care to service users safely and to an appropriate standard by receiving appropriate supervision. Regulation 23 (1) (a).**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The planning and delivery of care did not meet the individual needs and ensure the welfare and safety of people who used the service. Regulation 9 (1) (b) (i) (ii) (iii) (iv)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **The registered person did not have an effective system in place for ensuring any complaint made was fully investigated or resolved to the satisfaction of the complainant. Regulation 19 (1) (2) (c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not have effective systems in place to assess and monitor the quality of services provided. Regulation 10(1)(a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person did not ensure that people using the service were protected against the risks associated with unsafe or unsuitable premises. Regulation 15(1)(a) (c).**