Mr & Mrs S Cooppen

Faygate House

Inspection report

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Ratings

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

Overall summary

Faygate House provides accommodation and care for up to 23 people, some of whom are living with dementia. At the time of our visit there were 14 people using the service. The service does not provide nursing care.

This inspection took place on 12 and 16 December 2014 and was unannounced. At the time of our visit, the service had 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.

At our last inspection in June 2014, we found that some legal requirements were not being met. The provider was not taking appropriate steps to assess whether people had the mental capacity to make their own decisions and had not consulted a medical professional when making decisions about whether people should be resuscitated if they stop breathing. Some records were not available when required and others were not kept securely. The provider had failed to notify us of the deaths of two people using the service, which is required by law.

At this inspection, we checked to see if the provider had taken action to meet these requirements. We found that the required standards were still not met. Staff were not aware of the procedures they needed to follow under the

Summary of findings

Mental Capacity Act 2005 to ensure decisions about people's care were only made with the person's valid consent or within legal requirements. The provider was still not consulting medical professionals to assess whether resuscitation would be appropriate for each person. The provider had taken some steps to keep people's personal records more securely by locking the filing cabinet they were kept in and installing a lockable office door. However, the door was not kept closed when the room was unattended and other personal records were not kept securely.

Although people and their relatives felt the service was safe, we found a number of shortfalls. Risks were not always fully assessed and reviewed to make sure the safety of people and that of others had been fully considered. Some risks had been assessed and management plans put in place, but this was not consistent. We saw staff using unsafe lifting techniques when assisting people to move, which could put them at risk of injury. The risk of people developing pressure ulcers was appropriately managed.

The provider carried out checks and risk assessments around the safety of the premises. However, we found several risks that had not been identified or addressed. For example, the provider had not identified that a bath tap ran hot enough to cause serious injury to people through scalding. There was a fire risk assessment in place, but people did not have individual evacuation plans in case of fire.

Accidents and injuries were not consistently recorded and there was no system for reviewing trends arising from these to help prevent them in future. Although people were offered medical attention after accidents, it was not always provided it if they needed it.

People did not always receive their medicines safely, because medicines were not always stored and given as prescribed and there were no clear instructions about how some medicines should be given. In some cases, poor recording meant that we were unable to confirm whether or not people had received their medicines.

The home was visibly clean. However, we identified a number of risks related to infection control and prevention such as a lack of hand washing materials and infection control audits that were not thorough enough to ensure these were effective.

The provider had placed some restrictions on people's liberty to help ensure their safety, but had not followed the procedures outlined by the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) to ensure people's rights were properly considered. DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

Staff received training and supervision and attended staff meetings to support them in their roles. However, there was no training plan or annual appraisal system so the provider could monitor the individual training and development needs of staff. The provider did not consider specific training staff might require to meet the individual needs of people who used the service.

People were happy with the quality of food provided by the service. A variety of nutritious food was available to meet people's needs. Staff made referrals to the relevant healthcare professionals when people needed extra support to meet their nutritional needs. However, advice and guidelines from specialists were not recorded in individual care plans to guide staff.

People had access to healthcare professionals when required and for regular check-ups.

People and relatives were satisfied that staff were caring and treated them with respect. At times, however, people's privacy and dignity were not respected. Staff did not always explain to people what they were doing or pay them full attention when carrying out care tasks. Staff did not consider people's privacy when administering medicines.

Staff knew people well enough to build positive caring relationships with them, although this was not always reflected in care plans. They had access to information telling them how best to communicate with people. People were able to receive visits when they wanted and to personalise their living space in ways that were meaningful to them.

Staff were aware of the importance of keeping people comfortable and promoting their dignity as they approached the end of their life. However, they did not support people to plan ahead for this. We recommend

Summary of findings

that the provider consider relevant guidance about supporting people and their families to plan for the end of their lives to ensure their wishes and preference are known.

Although relatives were involved in planning and discussing people's care, there was little evidence that people using the service were consulted about their preferences. For example, people had baths according to a rota that did not take their preferences into account.

People's needs were assessed when they were admitted to the home, but assessments were not always regularly updated and fed into care plans. This meant that in some cases people's changing needs were not taken into account.

People had access to a choice of activities that were meaningful to them. They received support to meet their cultural and religious needs, where required.

There was a complaints policy in place. People and their relatives knew how to complain and were confident they would be taken seriously. The provider recorded any concerns raised and the remedial action taken but did not record any steps they took to prevent reoccurrence so it was not clear whether they had responded fully.

Although relatives and staff told us managers listened to what they had to say, people using the service did not always feel they could speak to managers. Some were unsure of who was in charge or told us they never saw the registered manager. He was not present during our inspection and did not attend meetings held for people, staff or relatives. Relatives said there was no clear hierarchy of leadership and it was unclear who was in charge. We did not find evidence that the registered manager was fulfilling their duties in terms of leading, supporting and monitoring the staff team.

The provider used meetings and surveys to gather the views of people and their relatives. They used the feedback to form an action plan, but this was not effective as it was not specific or measurable.

Quality audits were carried out at the service but these were not comprehensive, effective or carried out in a timely manner in accordance with the provider's policies. The audits failed to identify the concerns that we found and the provider had failed to address failings that we had previously told them to take action to address.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

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?

Inadequate

The service was not safe. Risks were not always identified and managed appropriately. Staff did not record incidents in a consistent way and there was no system in place to monitor and learn from them.

Some aspects of the premises were unsafe. People did not have personalised fire evacuation plans. Risks such as dangerously hot water had not been identified. The provider's infection control audit was not robust and failed to identify several infection risks.

The provider did not ensure that medicines were stored, recorded and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective. The provider did not follow procedures under the Mental Capacity Act and Deprivation of Liberty Safeguards to ensure that care was only provided with people's valid consent or within legal requirements if they were not able to consent.

Staff had access to training, supervision and staff meetings to help them carry out their roles effectively. However, their individual training and development needs were not monitored.

People received a variety of nutritious food that they enjoyed and were referred to specialists if they needed extra nutritional support. However, advice from specialists was not incorporated into care plans. People had access to healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring. Although people and their relatives felt they were treated with kindness and respect, we observed instances when people's privacy and dignity were compromised.

Staff knew how to communicate effectively with people and knew their needs and preferences, although this was not always clear in care plans.

People were able to personalise their living space and receive visits from relatives.

Staff knew how to promote people's comfort and dignity around the end of their lives, but because end of life care plans were not in place there was a risk that people's wishes might not be known and respected in this area.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Assessments were not always kept up to date to ensure people's care plans reflected their changing needs. People were not involved in planning their care, although relatives were involved. This meant people's preferences were not always taken into account.

People were supported to choose activities that were meaningful to them and suited to their abilities. People confirmed their religious and cultural needs were met.

There was a complaints policy and people were aware of how to complain. The provider recorded concerns that were reported to them by people and relatives and how they responded but did not record any action they took to prevent the concerns arising again.

Is the service well-led?

Inadequate

The service was not well-led. People and relatives did not know who was in charge or did not feel managers listened to them. People said they did not regularly see the registered manager and there was little evidence of the manager carrying out their duties and responsibilities at the home.

The provider sought people's views through surveys and meetings and used feedback to create an action plan, but this was not always followed through in a timely manner.

Quality audits were not thorough or regular enough to be effective and had failed to identify the failings we found.

Some of people's personal care records were not kept securely, meaning that their confidentiality was compromised.

Faygate House

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 16 December and was unannounced. It was carried out by an inspector and an inspection manager.

Before the inspection, we looked at the information we held about the service. We spoke with local authority commissioning and adult safeguarding teams. We reviewed previous inspection reports for this service.

During the inspection, we spoke with four people who used the service and eight relatives. We spoke with three support workers, the deputy manager and one of the two partners who operate the service. We looked at six people's care plans, four staff files and other documents relevant to the management of the service, such as audits and staff duty rotas. We observed care being carried out and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

The provider did not always assess and review risks and did not have appropriate management plans where risks were identified to ensure the safety of people and that of others. The staff carried out assessments to identify risks associated with the care and support people received and the impact on the individual and others so appropriate management plans could be develop to minimise these. Whilst there were some good examples where risk assessments had been carried out and plans to manage risks had been developed, we found that these had not been consistently used for all people who used the service. For example, where a person had a number of falls, we did not see a risk assessment in place and a plan to minimise the risk of falling. Where a person had a behaviour that could challenge the service, we also did not see a risk assessment in place and a plan to manage the risks to the person and others. Another person's records showed that they may have been prone to seizures, but there was no corresponding risk assessment or information available about the frequency, type or warning signs of the seizures or what action staff should take if the person experienced a seizure.

We observed a member of staff asking a visiting professional to help them transfer a person from an armchair to a wheelchair. The member of staff did not use lifting equipment and instead the member of staff and visitor moved the person by lifting them under their arms. Use of this technique could cause injury to people, staff or visitors. Staff told us lifting equipment was available at the home, but care plans did not contain information about whether people's needs had been assessed in relation to what moving and handling equipment was suitable for them, what their specific needs were or how staff should use equipment to assist them.

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

The provider carried out risk assessments in relation to the premises. For example, we saw risk assessments about bedrooms, bathrooms, carpet and stairs, the use of chemicals such as cleaning products and the spread of infection from the water system. We did not see risk assessments in relation to the low ceiling in the bedroom of a person on the second floor. Whilst the room was personalised, clean and well decorated, part of the ceiling was flat where there was a dormer and part was angled where the roof sloped. There were risks that a person could hit their head against the angled ceiling where the dormer wall ends and the ceiling starts.

We found that the provider did not have a system to ensure that items of equipment were maintained in a timely manner to show they were safe to use. We did not see up to date Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) certificates for the hoist and the lift. The certificates are issued after specific tests are carried out to show that lifting equipment is safe to use. In addition the provider did not have an up to date electrical portable appliances testing (PAT) certificate at the time of the inspection, to show that items of electrical equipment in the home were safe to use. The provider's own risk assessment systems had not identified that these were required, so they could take appropriate remedial action.

The provider did not have an adequate system to ensure safe water temperatures in bathrooms and had not identified that some temperatures were unsafe. A relative told us they had previously raised a concern that water was not hot enough. We tested the water temperatures from hot taps in the home's two baths and found that one ran at no more than 24°C despite running for five minutes. This meant that a person could not have a warm bath in that bathroom. The temperature of the water in the other bathroom was more than 50°C. According to Health and Safety Executive (HSE) guidance, "If hot water used for showering or bathing is above 44°C there is increased risk of serious injury or fatality. Where large areas of the body are exposed to high temperatures, scalds can be very serious and have led to fatalities." We informed the provider and they arranged for the water company to investigate.

The provider had a fire risk assessment but people who used the service did not have individual emergency evacuation plan in the event of a fire. We discussed this with the provider who said they would address this matter.

We looked at how accidents and incidents were managed in the home. We found that not all accidents/incidents had been recorded appropriately in the accidents/incidents book. For example, on the day of the inspection a person had a dressing on their forearm. We were informed they had sustained a small injury. There were no entries in the accidents/incidents records about that injury. Another

person had information in their file stating they had fallen and sustained bruising to their head, but this was not recorded in the accident/incident records. Although records were being kept individually, the missing entries in the accident/incident book meant that the provider was not maintaining an effective system for identifying trends or learning from accidents and incidents.

Some records showed that staff asked people if they wished to go to hospital after having accidents and medical attention was not provided if the person declined. Staff had not considered the need to assess people's capacity to make this decision with advice from medical professionals or the risks to people if they do not go to hospital. In one case, this could have led to a person's injury not being detected for a week. This practice therefore did not always promote the wellbeing and welfare of people.

We also noted that accidents and incidents were not reviewed in a systematic way by the provider to analyse these and to identify trends and patterns so appropriate action could be taken to prevent these. Accidents records contained a section for the employer to sign to show they had seen these and to identify if further action was required. We did not find any of the records that had been signed to show that the provider had analysed the incidents and if they had considered whether additional action was being taken following an accident/incident to prevent these from happening again.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people told us they were happy with how their medicines were given to them. One person said, "I know what I should be taking and they always give them to me at the right times." However, we found that medicines were not always managed appropriately to ensure people received their medicines as prescribed. Where people were prescribed creams and lotions, the instructions to administer these and the location where these should be administered were not always made clear on the medicines administration records (MAR) sheets. Staff administering medicines might therefore not know where these medicines should be applied.

Some medicines were signed for when received in the home to show that the quantity and instructions to administer these have been checked appropriately. However, other medicines were not signed for and there were no evidence that the quantity received had been checked. At least one medicine that remained from a previous 28-day cycle had not been carried forward. It was therefore not possible to determine the quantity that should be in stock and to confirm whether the person was receiving their medicines as prescribed.

The quantity in stock for four medicines for two people did not match the quantity that should be in stock. In each case, there were more of the medicines. This meant that the people did not receive their medicines as prescribed to manage their ill-health.

The provider had a medicines management policy. This said that the medicines trolley should be anchored to the wall to promote the security of medicines storage. We found that the trolley was not anchored to the wall. The policy also said that the temperature where the medicines were stored should to be monitored so that this did not exceed 25 degrees centigrade as many medicines have to be stored under 25 degrees centigrade so they remain safe to use. We noted that this was also not happening.

Where people were on a variable dose of medicines to be given when required we found that there were not always clear documented instructions to inform staff when to administer the medicines and in what quantity. This meant that people might not have been consistently receiving their medicines as and when they needed them.

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

We noted that the provider had suitable arrangements to manage controlled drugs (CD). These were appropriately stored and recorded when administered. A random check showed that the quantity in stock balanced with what should be in stock.

Relatives told us the home always appeared clean. We observed that most areas were clean and well maintained in appearance. However, we noted that the lounge carpet was stained in two places and there were other areas that could pose an infection risk such as rough or loose edges on linoleum floor coverings in bathrooms. This could provide an ideal breeding ground for bacteria as it is difficult to keep clean. Taps in one bathroom were encrusted with limescale, some of which came away when we turned the tap on. This could also harbour harmful bacteria.

Inadequate

Is the service safe?

Toilet facilities did not contain supplies of soap or hand towels and some had only cold water, meaning that people, staff and visitors were not able to wash their hands appropriately.

We looked at cleaning schedules and records and saw that these were completed daily. There were also infection control audits carried out every three months. However, these were not comprehensive and did not cover all potential risks. They did not look at handwashing, general standards of cleanliness, availability of materials such as hand wash and cleaning products, wear and tear, limescale or staff training. This showed that the provider had not adhered to Department of Health or other relevant guidance on infection control standards in care homes.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In some cases where actions to minimise risks were identified following risk assessments of the premises, these were actioned in a timely manner or steps were being taken to address these. For example, the risks assessment carried out recently in regards to the spread of Legionella, an infection that can spread through the water system, contained some action that the provider needed to take. They said that they were awaiting a quote for the work to be completed soon.

Where people were at risk of developing pressure ulcers, we saw they had been referred to the community nurse team and equipment had been provided as required to reduce the risk of them developing pressure ulcers. We saw the equipment for two people and noted that the equipment was appropriately set up and was operating at the right condition to ensure their effectiveness. Staff knew how to identify people at high risk of developing pressure ulcers, when to involve specialists and how to reduce the risk of them developing.

People and their relatives felt that the home was safe. One person told us, “I am quite vulnerable but I am safer here than outside.” One relative said “I am satisfied that my [relative] is safe in the home. The staff keep us informed if anything happens to my [relative]." Another relative told us, “[My relative] is clean, comfortable, warm and well fed.”

The provider had a policy on safeguarding adults at risk of abuse and the London multi-agency policy and procedures to safeguard adults from abuse. We also saw that safeguarding adults was discussed during one-to-one meetings so staff were clear about what to do if they come across incidents or allegations of abuse. All staff we spoke with were aware of the different type of abuse so they were able to identify this and knew the action to take if there were incidents or if they had suspicions that people were being abused.

One relative told us they or other members of their family visited often and said that staff were available in adequate numbers to meet people’s needs. Staff and one of the partners told us there were three staff during the day and at night there were two staff. The partner also helped to manage the home and they were supernumerary when they worked. The home had a duty rota and there were signing-in records when staff started or finished their shift. Although the information in these records was not comprehensively completed, overall it was adequate to confirm that the staffing levels as stated by the partner were being maintained.

The provider, however, did not have a system to assess and monitor staffing levels so appropriate changes could be made where required to ensure staffing levels were adequate to meet people’s needs. For example, the provider did not have a plan in place to monitor staffing levels in relation to people’s needs should the number of people using the service increase. We discussed this with the partner, who told us they used an employment agency to cover shifts if staffing needs increased.

We looked at the personnel records for four members of staff and saw that the provider carried out suitable recruitment checks before staff were able to work at the service. For example there were application forms, curriculum vitae (CV), employment references, medical history and evidence of the right to work in the UK. There have not been any new staff at the home for the past two years. We discussed the recruitment process with the provider and they were able to confirm the various checks that they carry out before people were employed by the service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in June 2014, we were concerned that the provider did not ensure that they fulfilled their legal responsibilities under the Mental Capacity Act (2005).

At this inspection, people told us staff sought their consent before carrying out personal care tasks and always asked if they were ready before beginning. Staff recorded this in people's notes. However, staff did not have adequate awareness of the Mental Capacity Act (2005) and the legal requirements for making decisions about care and treatment on behalf of people who lack capacity to do so. Staff told us they would either make a decision on behalf of someone who could not consent or would ask their next of kin to consent on their behalf. Staff were not familiar with assessments of mental capacity or the best interests process outlined by the Act that should be followed under these circumstances.

We looked at Do Not Attempt Resuscitation (DNAR) forms in four people's files. These are decisions that are made in relation to whether people who are very unwell should be resuscitated if they stopped breathing. One of these had been completed on the correct form with the person's GP involved in making the decision. The other three used a form developed by the service and only involved people's relatives and staff from the home in making this medical decision. This meant that the provider was still failing to act within legal requirements.

Staff, and the partner, did not understand the processes outlined in the Mental Capacity Act about how and when people can legally be deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). These require the provider to assess people's capacity to consent to any restrictions placed on their liberty as part of their planned care, and for applications to be made to a DoLS assessor through the relevant authority. We observed that people's liberty was being restricted because one person had rails on their bed that may have prevented them from getting up and because the front door was locked with a key that only staff had access to. Staff explained that the door was locked because two people were diagnosed with a condition that may have caused them to become disorientated to time and place, putting them at risk if they left the home unaccompanied.

We looked at these people's care plans and risk assessments but there was no information on how or whether the condition was likely to affect them from making decisions about their safety. They did not have risk assessments showing that they had been judged to be at risk in this way, there were no assessments of their capacity in relation to consenting to the restrictions and no DoLS applications had been made. Although the provider demonstrated that they had obtained the correct forms to request a DoLS authorisation, these had not been completed at the time of our visit. People were therefore being deprived of their liberty without the appropriate procedures being followed to ensure their human rights were upheld.

Two people's relatives told us they had a lasting power of attorney (LPA) which meant they could legally give consent on behalf of their relative. We checked both people's files and found no evidence that the provider had checked or taken a copy of the LPA to ensure it was legally valid and applied to social care decisions. Each person had an information form that relatives had completed, including a question asking whether they had LPAs. However, the provider did not carry out checks to confirm this and to ensure decisions were being made by the right person and at the right level and thereby helping to protect people's rights.

The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One relative told us that the staff knew how to care for and support their relatives. We saw a number of training certificates in a folder to show that staff had completed training in a number of areas. The deputy manager told us that a range of training was provided annually for all staff and all staff had to attend. The provider, however, did not maintain an individual training and development plan according to their policy on training so it was clear what training each member of staff had completed and how the provider was supporting them with their individual training needs. We saw training certificates to show that staff had received training in a number of areas that the provider considered necessary for staff to be able to provide care and support to people. However, there was no system to monitor and assess the effectiveness of the training

Is the service effective?

undertaken by staff. For example, there was no competency assessment for staff in relation to the management of medicines or manual handling, where we had noted concerns.

The service did not have an appraisal system to assess the individual performance of staff and to support them in their personal development. We did not see any records in staff personnel records to show they had had an appraisal and staff confirmed they had not received an annual review of their performance.

The above constituted a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw records to show that staff had one to one meetings (supervision) with their line managers as a way of supporting them in their role and to assist with their personal development. Staff told us they found these useful to help them perform their roles effectively. Team meetings were also arranged where staff were able to discuss issues, such as the provision of activities, what constitutes abuse and their roles in caring for and supporting people who use the service.

We saw evidence that staff had involved professionals such as dieticians or speech and language therapists where people had specific needs relating to diet or eating. They monitored people's weight monthly and any significant changes triggered a referral. However, these people either did not have nutrition care plans or their care plans had not been updated with new information and guidance from professionals. For example, one person had seen a professional in May and August 2014 and received guidelines about meeting their dietary needs, but the information had not been collated and the care plan had not been updated since April 2014. People were therefore at risk of receiving inappropriate care and support around meals because staff may not have had access to up to date information about their nutritional or eating support needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All people we spoke with said they enjoyed their meals. People's meals, including the meals that needed to be pureed so people could eat them, were well presented. They were offered enough to eat. There was a four weekly menu cycle that was adhered to by the chef. We saw that there were ingredients in the kitchen for the chef to prepare meals according to the menu. People told us they received support to eat their meals, where necessary. They said there was fresh fruit available after every meal.

The chef had a good knowledge of the likes and dislikes of all people who use the service and ensured each person received meals they enjoyed and according to their choices. We saw the chef asking people in the morning which meal choice they would prefer for lunch. One person told us, "The food is very good. Some dishes I don't like but the cook gives me an alternative."

Another person's relative told us, "They make sure [my relative] has enough water." We observed throughout the day that people had access to hot and cold drinks as staff regularly offered them to people.

People and their relatives told us they were supported to access healthcare when they needed to. One person said, "I see the chiropodist regularly. The doctor and dentist come to see people every week." Another person's relative told us how the service had worked alongside physiotherapists to help their relative manage their deteriorating mobility. The home involved professionals such as community nurses in people's care when required. Where people received nursing care, they had separate nursing care plans and records that had been completed and maintained with input from nurses. This helped to ensure that visiting professionals had access to the information they needed.

Requires Improvement

Is the service caring?

Our findings

One relative said, "The home is very good and staff are very caring." People told us staff knew them well in terms of their needs and preferences. One person told us, "They are very caring and remember what I like and what I don't like." Another said, "Staff are charming and helpful." We observed staff chatting with people about their interests, such as asking whether they had seen a televised football match the previous day. One member of staff invited a person to look at some photographs together, which the person appeared eager to do.

We observed during our visit that one person appeared distressed and anxious, calling out and telling us that they were worried and did not know how to cope. We informed one of the members of the provider's partnership, who told us this was the person's normal presentation but agreed to ask staff to reassure the person. We later saw staff speaking to the person in a soothing manner and distracting them by offering a magazine.

However, on some occasions, we observed that staff were failing to respect people's dignity. For example, a member of staff approached one person 15 minutes before lunch was served, put a clothes protector (bib) on them without explaining what they were doing and then left. When the person's meal arrived, the member of staff supported them to eat by using a spoon that they brought to the person's mouth so they could eat. During this time, the member of staff did not speak to the person but on two occasions they got up and left the person without explaining what they were doing and once they turned to speak to another member of staff while still feeding the person. On one occasion, we noted that the member of staff was watching television while feeding the person, and also saw that when the member of staff left, the person began feeding themselves. This showed that the person's independence was also being compromised as they did not require the level of support that was given to them.

During the mealtime, we saw staff approaching another person who was eating their meal and asking them to take a liquid medicine. The person declined, saying "It'll make me sick." Staff continued to tell the person they needed to take the medicine and did not offer any options such as waiting until they had finished eating. They explained to the person what the medicine was for in front of other people at the table, which compromised the person's privacy around their medical condition. We noticed that after the staff left, the person said they were unable to finish their meal and did not eat the rest of the food on their plate.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication. This was useful in helping staff build positive relationships with people by communicating in ways that were appropriate to them.

People told us they had opportunities to decide how their bedrooms should look and we saw they were personalised to suit people's tastes. One person showed us items of sentimental value that they had brought with them and used to decorate a communal lounge. They told us, "I'm comfortable because I've got things from my own home" and "I have a nice room."

Relatives told us they were invited to take part in discussions, and were involved in decision making, about their family members' care. We saw forms that had been sent to relatives asking how often they would like to meet to discuss care and records showed their requests had been granted. One relative said, "They keep me informed and tell me how well [my relative] eats." People said staff listened to them when they expressed their views about their care.

The home had an open visiting policy. People were able to meet their relatives in the communal areas or in the privacy of their rooms. One relative said, "I can sit with [my relative] and have a meal if I want to when I visit." There were other places around the home, where people could sit with their relatives so they had privacy and could spend time together.

One person told us the service had helped them improve their independence in some areas. They said, "I've learned to do things for myself. I can use [mobility equipment] now."

Staff knew about the importance of making people comfortable as they approached the end of their lives. They talked about how they would preserve people's dignity and comfort by allowing them privacy, keeping them hydrated and making sure they were clean.

Requires Improvement

Is the service caring?

However, there was no information in people's files about their end of life wishes, such as where they wished to die, religious and funeral arrangements and whether they preferred to be buried or cremated. Staff told us they would discuss this with families "when the time comes." However, this meant that people might not have the opportunity to express their own preferences while they were still able to. Therefore there was a risk of their wishes around the end of their lives not being respected.

We recommend that the provider consider relevant guidance about supporting people and their families to plan for the end of their lives to ensure their wishes and preference are known.

Requires Improvement

Is the service responsive?

Our findings

People and relatives we spoke with were satisfied with the standard of care provided in the home. On relative said, "There are always staff around and my [relative] always appears well cared for - he is well shaven and dressed." However, we found that the provider did not always ensure people had comprehensive care plans that reflected their needs. There were therefore risks that people might not receive the care they required.

Care records showed people's needs were assessed before they were admitted to the home. All people had an assessment of their needs in their care plans. However, these were not always updated to make sure people's changing needs were taken into account. One person's file contained assessment tools designed to measure and monitor their risk of malnutrition and pressure ulcers. Their scores indicated that they were at risk meaning the assessment should be repeated monthly, but it had not been repeated for six months after the person's admission to the home. One of their assessments had a date that indicated it had been done while the person was absent from the home. This meant it may have been based on inaccurate information and did not give the person the opportunity to be involved or to express their views about their needs.

Some other information in people's care records was included that was specific to people, such as the factors that might contribute to the risk of them falling. For one person, this included a lack of confidence and for another person, their preferred type of clothing was a factor. However, this was not the case for all people. We found no information in another person's care plan about them being anxious as part of their presentation, input from professionals such as mental health services, or how staff should support them in these circumstances. Their care plan therefore lacked information about how to manage this need.

The above showed that there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although some information in care plans appeared to be personalised because first-person statements such as "I want to have a bath every week" were used, we found that these statements were copied into other people's care plans. The home had a rota showing when each person would be supported to have a bath once a week. One person confirmed this and said that, although the arrangement suited them, "you don't really have a choice – everyone has a weekly bath." This meant there was a risk that people's individual personal care preferences or needs were not being considered.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had recently confirmed arrangements for an activities worker to attend the home three days a week. People and their relatives told us activities were varied to suit their needs. One person said, "I get to do quizzes, which I prefer. I find them inspiring." During our visit, the activities worker told us they had planned to do one activity but people had said they would prefer something else, so they had changed the plan to suit people's preferences.

At the time of our visit, the home was decorated for Christmas. People told us they were able to celebrate as they wished. One relative told us about the home's "really nice" Christmas party, to which families were invited. Two people told us they liked to watch religious television programmes and that their needs were met in this area. Staff told us a priest visited the home regularly to perform a communion service for those who wanted to take part. They told us they would involve other religious leaders if required but that at the time of our visit nobody using the service practised any other religions.

The provider had a complaints policy and procedures to deal with complaints. A copy of the complaints procedure was displayed in the foyer of the home. People or their relatives were aware of this. One relative said that if they wanted to complain, "I would go to the little office on the ground floor, but I have had no reasons to complain." Another relative said, "They always take our comments on board and they call you back if you want to speak to a manager." A third relative said "I have no complaints and I have never found any faults with the service."

We saw a number of records that had been entered in a 'complaints book', but were more about concerns that had been received or identified by the provider. The records showed that the concerns were investigated to identify the causes and remedial action that was required. However, we

Requires Improvement

Is the service responsive?

did not see any records of action being taken by the provider to prevent recurrence. We discussed this with one of the partners who agreed and said they would record this information in the future.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, we identified concerns around confidentiality of records. We were concerned that the confidentiality of people's records was compromised because they were kept in an unlocked filing cabinet and on shelves in an unlocked room. At this visit, we found the provider had taken action to address this as they had fitted a new office door with a robust lock and the filing cabinet containing care plans was locked throughout our visit. However, there were still some files containing personal information, including medical information, on a shelf and attached to the wall in the office. Although the door was capable of locking, we observed that it was open and unattended when we arrived and remained open throughout our visit. On several occasions, we noted that no staff were present in the room and this meant people's records could be inappropriately accessed by other people or by visitors.

We also noted that the medicines file, which contained details of people's medicines and medical conditions, was left on top of a trolley in a communal hallway. This remained in place throughout our visit except when staff were administering medicines and could have been accessed by people or visitors.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Providers are required by law to notify CQC of certain incidents that occur during the provision of care. We discussed this with the provider at our previous inspection as they were failing to send the notifications. During this inspection, staff told us there had been no deaths at the home since our last visit so we were unable to verify whether the provider was meeting the requirement to notify us of deaths of people using the service. However, we found through discussion with the local authority safeguarding team and from looking at records that one person had sustained two broken bones as a result of a fall at the home in July 2014. We did not receive the serious injury notification the provider was required to send to us.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2010.

People and their relatives did not feel leadership was visible. One person said the managers listened to them "to a degree" and "it's all right if they do listen otherwise it's not worth your while." One relative said they knew the deputy manager but did not know who the registered manager was. One person said, "We don't see much of [the providers]. You occasionally get to talk to them. There have been different people in charge." Another person said, "I don't see much of [the providers]. I've only met them once." Relatives told us they could approach the deputy manager to discuss issues and would benefit from a clear hierarchy so they knew where lines of accountability lay.

The service has not always had a clear management structure to ensure there were clear lines of responsibility and accountability. The provider is a partnership and one of the partners is the registered manager. He was not present during the inspection. The staffing rota showed he was on the duty rota for one week of a four weeks cycle of duty rota, but he was not on duty in the home. We also looked at minutes of staff, one- to-one and house meetings and noted that the manager had no input in these. Most of the role was being assumed by the other partner or the deputy manager. There was therefore little that the registered manager was doing in relation to leading the team, monitoring its performance and supporting them in delivering quality and safe care to people.

The provider had a policy called 'The management ethos'. This talked about leading by example, maintaining a clear sense of direction and ensuring the management approach created an open, positive and approachable atmosphere in the home. Our findings during the inspection showed that they were not following this procedure. They also had a policy about staff code of conduct. When we asked staff about this and the values that were important to the organisation and to them, they were unable to tell us about these. This meant that the provider did not operate a system where staff worked and performed to a clear set of values and behaviours on which the organisational culture was based and which aimed at promoting excellence. A system was also not operational to ensure decisions about the care of people were made at the appropriate level by the appropriate person.

People and relatives had opportunities to contribute their views about the service. One relative said there were house meetings that were arranged for people and relatives. Minutes were available to confirm that these meetings took place and these showed that people and their relatives were asked for their views on how to improve the service. People and their relatives were also given satisfaction

Inadequate

Is the service well-led?

questionnaires to complete every six months to give their views about the service. We saw three such questionnaires that were completed in September. The provider carried out an annual analysis of all feedback received from people and relatives including feedback from questionnaires, cards and letters. They then prepared a report and whilst overall comments from people were positive, the provider had identified some areas for improvements and had drawn up an action plan. We found that the action plan was not specific, measurable and did not have a timescale in place. For example, the report in April 2014 said there would be a redecoration programme in place, but when we asked for this, the partner said they had not prepared one yet. We discuss this with them and they said they would address this matter.

The quality assurance procedure stated that the manager had overall responsibility for quality management in the home and that an annual audit would be carried out. We saw a number of audits that had been carried out, but these were not comprehensive or effective and had not been carried out in a timely manner. For example, the care plans audits were last completed in 2013 and none were carried out in 2014. There were medicines audits but these were not completed monthly as indicated in the quality assurance procedure. An infection control audit was carried out but this was inadequate and not based on current guidance or good practice. It consisted of five points, one of which was not applicable in the home. Our findings during the inspection also showed that the quality assurance system had not picked up the concerns we found so these were identified and addressed. In addition, where we had identified areas where the provider was not meeting regulations during a previous inspection, they had failed to take action to fully address these areas.

The above constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us the deputy manager and the partner we met during the inspection were available if they needed to discuss any concerns and would take action to address these. Staff meetings were also arranged monthly. They told us that even if they were unable to attend staff meetings they could still add discussion points to the agenda and would receive minutes from the meetings.

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	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person did not protect service users from identifiable risks by means of the effective operation of systems designed to prevent, detect and control the spread of a health care associated infection or by the maintenance of appropriate standards of cleanliness and hygiene in relation to the premises. Regulation 12(1)(2)(a)(c)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not make suitable arrangements to ensure the dignity and privacy of service users and that service users are enabled to make, or participate in making, decisions relating to their care or treatment. Regulation 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, including by receiving appropriate training, professional development and appraisal. Regulation 23(1)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

Regulation 18 Care Quality Commission (Registration) Regulations 2009 Notification of other incidents.

The registered person did not notify the Commission without delay of incidents which occurred whilst services were being provided in the carrying on of a regulated activity. These incidents include any injury to a service user which, in the reasonable opinion of a health care professional, requires treatment by that, or another, health care professional. Regulation 18 (1)(2)(b)

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not ensure care was planned and delivered in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. Regulation 9 (1)(b)(i)(ii)

The enforcement action we took:
We issued a warning notice to the provider to be compliant with this regulation by 27 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care, by means of the effective operation of systems designed to regularly assess and monitor the quality of the service. The registered person did not identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. The registered person did not establish mechanisms for ensuring that decisions in relation to the provision of care and treatment for service users are taken at the appropriate level and by the appropriate person. Regulation 10(1)(2)(b)(v)(c)(i)(d)(I)

The enforcement action we took:
We issued a warning notice to the provider to be compliant with this regulation by 27 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

This section is primarily information for the provider

Enforcement actions

The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the handling, using, safe keeping and safe administration of medicines. Regulation 13

The enforcement action we took:
We issued a warning notice to the provider to be compliant with this regulation by 27 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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, or the consent of another person who is able lawfully to consent to care and treatment on that service user's behalf. Where this did not apply, the registered person did not establish, and act in accordance with, the best interests of the service user. Regulation 18

The enforcement action we took:
We issued a warning notice to the provider to be compliant with this regulation by 27 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person did not keep service users' records securely and did not maintain accurate records in relation to the managing and carrying on of the regulated activity. They also did not ensure service users were protected against the risks of unsafe or inappropriate care that can arise if accurate records about each service user in relation to their care and treatment was not maintained. Regulation 20 (1)(a)(b)(2)(a)

The enforcement action we took:
We issued a warning notice to the provider to be compliant with this regulation by 27 February 2015.