Howson Care Centre Limited

Howson Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Howson Care Centre on 25 October 2016. This was an unannounced inspection. The service provides care and support for up to 83 people. When we undertook our inspection there were 79 people living at the home. This is a large premises which is split into different units to take into consideration the different types of people the provider is registered to provide services for, such as people with mental health problems, physical disabilities and those living with dementia.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses, mental health needs or because they were experiencing difficulties coping with everyday tasks, with some having memory loss.

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.

We found that people's health care needs were assessed, but care was not planned and delivered in a consistent way through the use of their care plans. People were not involved in the planning of their care. The information and guidance provided to staff in the care plans was unclear. Risks associated with people's care needs were assessed, but plans were not put in place to minimise risk in order to keep people safe.

The care plans and risk assessments did not fully reflect the needs of people and what action staff should take to prevent a person from being at risk of harm. The clinical governance measures were not robust enough and did not reflect whether lessons had been learnt from audits to measure the quality of the service. You can see what action we told the provider to take at the back of the full version of the report.

People had been consulted about the development of the home. However, the auditing system was poor and there was no analysis of quality checks, or lessons learnt passed on to staff.

You can see what actions we told the provider to take at the back of the full version on the report regarding the review of care plans and ensuring quality checks are more robust.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there was one person subject to such an authorisation.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period. The home was divided into different units and a core staff worked in each unit, with some staff working across units depending on people's needs.

People were treated with kindness and respect by the majority of staff. Staff in the home took time to speak with the people they were supporting. However, some staff had a poor attitude to people and did not treat them with respect. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

People had a choice of meals, snacks and drinks. Meals could be taken in dining rooms, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. However, there were no menus on display so people could not remind themselves of the choices they had made.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. On-going training was available for all staff. However, the training sessions for registered nurses was behind schedule.

Areas of the home were in need of repair. Some areas had chipped woodwork and unkempt furnishings. There was a lack of a maintenance plan.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Checks were not made to ensure the home was a safe place to live.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse. However, risk assessment were not always up to date and staff did not ensure people were protected from harm.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing. However, menus were not on display, so people could not be reminded of their choices.

Staff received suitable training and support to enable them to do their job. However, training for registered nurses was behind schedule.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff.

The majority of staff ensured people's dignity was maintained at

all times. However, some staff showed a lack of respect for people in their attitude and language.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was planned, but not reviewed on a regular basis with them. The care plans did not fully explore the needs of people and how other agencies could help them.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

An analysis of audits was not undertaken to measure the delivery of care, treatment and support given to people against current guidance.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

The views of visitors and other health and social care professionals were sought on a regular basis.

Howson Care Centre

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 25 October 2016 and was unannounced.

The inspection was undertaken by two inspectors a specialist advisor who had expertise in mental health and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority and NHS who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to health and social care professionals before the site visit.

During our inspection, we spoke with nine people who lived at the service, two relatives, four members of the care staff, two registered nurses, a housekeeper, an activities organiser, two members of the kitchen staff, the administrator and the registered manager. We also observed how care and support was provided to people.

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.

We looked at eight people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, minutes of meetings and audit reports the registered manager had completed about the services provided.

Requires Improvement

Our findings

People told us there were sufficient staff to meet their needs. However, two people we spoke with voiced concerns over staffing levels when staff did not work because of illness or holidays. This made had impact on their care needs. One person said, "Yes, they can cope with us. They are there when you want them straight away." Another person told us, "You don't have to wait long if you want something." One other person told us, "Sometimes they are short if people are ill or go on holiday, but they do cover them." However, a relative told us, "No, I've seen how stretched they are when understaffed, when they phone in sick and the like."

Although people told us they felt safe at the service, the provider did not have systems in place to analyse incident and accidents to reduce the risk of them occurring again. For example, accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was a process in place for reviewing each individual accident, incident and safeguarding concern on a monthly basis, but this was completed on an individual incident basis. There was no analysis each month to show themes and trends, which would help to identify specific safeguarding concerns. Staff told us that changes in care needs were discussed at staff meetings and daily shift handovers, which they said was effective.

We were invited into seven people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. However, staff had not taken into consideration when writing the care plans of environmental risks for some people, especially those with mobility problems or loss of vision. This did not ensure rooms were free of trip hazards from trailing wires and ensuring furniture was in a good state of repair. We also observed that in some areas of the home there were trip hazards where staff had left equipment. This included a vacuum cleaner with trailing wires, a bin on wheels containing aprons and towels with no brakes and an unattended three wheeled walking aid. All items were in areas where people who were unsteady were walking.

The main entrance to the home was through a reception area where people either rang a bell to summon staff to enter or who had authorised access. Entry to various parts of the building required a code or swipe card. Staff told us that people could have access if they had been assessed as being capable of retaining that information, but this was not recorded in their care plans. Some people had keys to their bedrooms. One person told us, "I don't like people going through my stuff, its best." People had name plates on their bedroom doors, which enabled them to identify which room was theirs. Some people choose to have pictures on their doors which meant they could recognise them quickly. There were also signs on the doors

indicating what each room was used for, for example, a sitting room or toilet. However, in one unit where people lived who mainly had memory problems there were no directional signs in corridors to direct people around the unit, other than fire exits. This could mean that people who had a poor memory could walk for a long time until they found where they wanted to be.

There were areas of the home which needed some refurbishment. Woodwork was badly chipped and marked. On some doors locks had been repositioned or removed and the resulting holes had not been made good. There was little visually stimulating wall decorations. In one unit the social seating and eating areas were like corridors with people constantly passing through. One staff member said, "We've been saying for ages it's like a corridor, people always walking through. We need a bigger area for socialising." However, one relative told us, "It's not a beautiful, cosy little place. It's shabby, but it's a wonderful place where the staff go out of their way to do the very best for people."

Staff told us that the staffing levels were good. One staff member said, "Staffing is ok. We have access to staff across the home. If occasionally we don't have staff in our unit, then staff will work extra shifts." Another staff member told us, "We have enough staff. It's brilliant." Staff told us they could voice their opinions about staffing levels.

The registered manager told us how the staffing levels had been calculated, which depended on people's needs and daily requirements. These were reviewed on a monthly basis by the registered manager. The registered manager discussed the staffing needs for some people with complex needs with commissioners of services. This was because those people required more input by staff on a one to one basis. We saw in the care plans when those discussions had taken place. Staff informed us of the people who required this extra input and we saw how extra staffing was helping one person to fulfil their needs. Although an extra member of staff was on duty in that unit they were not identified on the rota. This was because staff members took it in turns to sit with the person. Staff told us this worked as the person did not get bored talking to the same staff member all day. There was a contingency plan in place for short term staff absences such as sickness and holidays, which agency staff fulfilled. However, staff preferred to work extra shifts themselves rather than use agency staff and we saw on the staff rotas agency staff were rarely used. The registered manager told us that they were in the process of trying to recruit an additional registered nurse to support the service.

People and relatives told us they felt safe living at the home. One person told us this was because there were a lot of cameras. There were cameras in the corridor areas. Notices were on display in the reception area alerting people to the use of cameras and people were informed of their use prior to admission. Staff told us the presence of cameras defused situations which could sometimes occur between people as they knew the cameras were there and would talk with their peers and staff rather than becoming aggressive. They had also been used when staff had not acted appropriately with people as part of disciplinary hearings.

We observed staff handling situations and supporting people when they become distressed and could put them and others at risk of harm. Staff were calm, talked with each person and offered alternatives to how they would like to spend their time and where they could sit. People told us staff dealt well with those situations and they felt safe. One person said, "Staff take them away from the area, calm them down and sort it out of the way." When talking about the behaviour of some people, a relative told us how staff had dealt with a situation. They said, "Very well, one person was being aggressive and loud." Staff told us they dealt with each situation quickly so people would not be alarmed and would feel safe.

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur, with the exception of one staff member. This was raised with the manager. They knew the processes which were followed by other agencies and told

us they felt confident the registered manager would take the right action to safeguard people. This ensured people could be safe living in the home.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. For example, where people had a history of falls and difficulties mobilising around the home, falls assessments had been completed. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person. Permission for the use of bedrails had been sought and were in place. This was recorded in each person's care plan. We observed staff assisting people to use a variety of walking aids and wheel-chairs throughout the day. Staff gave reassurance and advice to each person on how to walk safely or use their wheel-chair around the building. This was to ensure each person was capable of being as independent as possible and did not cause harm by being mindful of others who could not walk as easily as those in wheel-chairs.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because they would become anxious when hearing a loud noise. A plan identified to staff what they should do if utilities and other equipment failed. Staff were aware of how to access this document.

We saw that recruitment checks were carried out prior to people being employed at the service. The provider asked for two references, proof of identification and undertook checks with the Disclosure and Barring Service (DBS) to ensure that people did not have any past convictions that would present them as a risk to people living at the service.

People told us they received their medicines and understood why they had been prescribed them. One person said, "I get it on time." They went on to tell us what was administered and which staff helped them. However, when we observed people receiving their medicines they did not appear to know why they were taking some medicines. We passed this on to the staff to ensure the person was informed. Another person told us, "I'm a bit of a handful. They make sure I take it." Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in locked areas in each unit. Records about people's medicines were accurately completed. Where there was a need for staff to take blood from people, due to the types of medicines people had been prescribed, all charts had been completed. Registered nurses had undertaken a course in phlebotomy (the taking of blood), so they could do this without people having to go to the GP. Staff told us this was better for people as they were used to the staff and would be less anxious. A separate register was kept for those medicines which were required to be recorded in a separate book and there was accurate recording by staff. The registered manager told us that there had been a recent audit by the local GP surgery. There had been problems with ordering medicines which the manager was working to resolve with the GP.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. Staff who administered medicines had received training. Reference material was available in the storage areas.

Good

Our findings

The staff we spoke with had been working at the home for a long time. However, they told us that their induction programme at the home had suited their needs. They told us what the programme had consisted of which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. This covered practical training such as manual handling. The provider ensured that there were incentives for people to complete their induction and develop their skills and knowledge through the wage structure. The registered manager told us that all new staff were now registered for the new Care Certificate. The provider had embraced the National Care Certificate which sets out common induction standards for social care staff.

We saw that there was a training system in place commissioned through an external company. This system was flexible and enabled the provider to identify six units a year that they felt would be most appropriate to the needs of staff at the time. Staff were expected to work through 'knowledge books' in groups or as part of workshops and then their knowledge would be tested and marked by the training company. This would highlight where more training and development would be needed. There was also regular training around issues such as infection control, diversity and equality and this year they were completing training in dementia. Some of the training undertaken was from trainers who gave practical demonstrations such as the use of fire appliances. The training matrix showed that training for most care staff was up to date. However there were gaps in the training which registered nurses had undertaken. One member of staff had independently undertaken further training to support them in their role. A staff member told us how taking part in a virtual dementia training session had given them a better understanding of people they looked after who had loss of memory.

Care staff received regular supervision, according to the records. However, registered nurses were not receiving regular supervision which would enable them to discuss their development and training needs with their manager. There were mixed views of staff on how often they received supervision. Some stated they had received this every couple of months, whilst others stated there was a more an informal approach by their supervisors on when they required formal supervision. Registered nurses were independently seeking advice about their revalidation with the Nursing and Midwifery Council (NMC). This will ensure they remain on the 'live' register with the NMC and seen fit to practice as registered nurses. The registered manager was checking the progress of the NMC revalidation process with each registered nurse.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirement in the DoLS. One application had been submitted to the local authority and authorised. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS. Staff gave us a good résumé of what the MCA and DoLS would mean for the people they looked after.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times when it had been appropriate for best interest meetings to be held and assessments completed to test their mental capacity and ability.

People told us that they liked the food. One person said, "Very good meals. They come around with a menu. They feed us well." Another person told us, "Quite good, always hot and get a choice. We have a menu, but they'd make something for us if we didn't like the choices. We get enough." A relative told us their family member was becoming difficult to please regarding their food preferences but told us, "They'll make things just for [named relative[."

Staff knew which people were following special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet and if they needed assistance. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes, foods to avoid and the type of diet required. This ensured people received what they liked and what they needed to remain healthy. They said some people liked to keep their own food choices in the kitchen such as pizzas.

People told us they could choose their meal the day before, but were always asked on the day if they still would like their choice. Menus were not on display in the dining rooms, but within the kitchen area. Most people did not have access to this area, so this only aided staff in being able to tell people the menu choices. We saw that staff ensured people were well hydrated during the day. People were offered hot and cold drinks regularly by staff, but staff also made drinks for people when asked to do so. Staff took meals to people who preferred to eat in their rooms. They ensured each person was sitting comfortably and had all the utensils and condiments they required.

We heard staff speaking with relatives about hospital appointments and home visits, after obtaining people's permission. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made. We saw staff record events and conversations in the care plans. People told us they had appropriate and timely access to health care. One person said, "If you're not very well, they get you to see a doctor." A relative told us their family member had to go to hospital recently and they had accompanied them. They told us that they had informed the hospital that staff at the home were in a better

position to answer their questions as they had confidence in the staff.

People told us staff treated them with dignity and respect at all times. One person said, "They close my curtains when I'm going to bed and undressing and dressing." Another person said, "They respect my wishes to speak with them in private so we usually go to my bedroom."

We observed staff knocking on doors prior to being given permission to enter a person's room. They asked each person's permission prior to commencing any treatment and respected if they wanted pain relief medication prior to commencement of treatment.

People told us staff obtained the advice of other health and social care professionals when required. One person said, "When I need my social worker they get them." In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people's behaviours had changed and when they required health checks such as flu vaccinations. Staff had recorded when people had seen the optician and chiropodist. Several people had hospital appointments which they had attended. Staff had recorded outcomes of those visits. Staff told us they had a good rapport with other health professionals and felt supported by them when they required assistance. This was affirmed by the health and social care professionals we spoke with before our visit.

Requires Improvement

Our findings

We observed mixed reactions of staff to people's needs. The majority of staff approached people in a kindly manner. They showed a great deal of friendliness and consideration to people. They were patient and sensitive to people's needs. For example, when someone wanted a drink, staff stopped what they were doing and fetched them a drink. We saw staff took time to respond and engage with people who spoke to them.

However, staff did not always ensure that the dignity of people using the service was protected. For example, we saw that a person had gone to use the bathroom and left the door open. A member of the opposite sex was entering the bathroom. A staff member walked past and called to the second person 'come out please', however they did not stop to intervene to ensure that the person left or to close the door. As soon as they had walked past the second person simply returned to the bathroom.

We observed the lunchtime meal, which in three dining areas was disorganised. Some people walked around the dining areas as they found it difficult to sit for long periods to eat and this ensured staff could encourage them to eat. We saw that those people ate their meal. However, some people found this distracting when they were eating. We observed staff sitting with people who needed help to eat and drink. They spoke kindly to them, maintaining eye contact and informing them what was on the plate or bowl. Staff did not hurry people. Staff were calm, gave encouragement to get people to eat and ensured people had something to eat. For example, one person found it difficult to settle, so staff watched as they ate standing up. We observed that when people had food on their face staff asked whether they could wipe this away, which they did gently. When food had been spilt on clothing staff asked if the person would like to change and guided them to their bedroom.

As were we sitting alongside a person eating their lunch, another person who had come over in their wheelchair to join us was moved away with no discussion at all. It is likely that the staff member was well-intentioned and concerned about the person interfering in the conversation between the inspector and the first person; however it would have shown more respect to the person if they had been asked to move. As they were being moved the staff member said, 'You be a good gentleman'. An apron was then put over their head, again with no discussion or request for consent. The person asked, 'What are you doing?'

We observed one member of staff who appeared quieter in their dealing with people. They walked around very quickly with little social interaction or acknowledgement to people. One occasion the same person was heard to say to a person, "You must be patient and wait," as they walked away from that person. This person

had been continually asking why they were not going out, but still did not get an answer.

People told us they liked the staff and felt well cared for by them. One person said, "Staff are very kind. I like it here. I really do." Another person told us, "Staff are fine, okay, talk to you a lot. They do support me and are caring." A relative told us, "They are absolutely great. I do phone in a lot and I find them all very helpful." Another relative told us, "They are not condescending. The people are treated with dignity and respect and I've never seen anybody made to feel little."

People were given choices throughout the day if they wanted to remain in their bedrooms, bed or where they would like to sit. Some people joined in happily and readily in communal areas. Others declined, but staff respected their choices on what they wanted to do. There were also quiet areas in corridors where people could sit. We observed people in those areas, some with their relatives and other people, and some with staff. In one unit people living on the first floor were told by staff they were 'only allowed' to use the ground floor between 2pm and 4:30pm each day. Some people told us this restricted their access to social activities, when they would like to choice when to take part in activities such as internet use and use the pool table. However, people were able to attend the ground floor for periods of the day and at other times people were encouraged to have quite time in their own areas of the home.

Some people either through choice or because they were ill choose to remain in bed. We observed staff attending to people's needs. They ensured they answered people's call bells promptly, politely asked what they required before fulfilling the person's wishes.

The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made.

During our inspection we also observed staff helping several people whose behaviour was challenging to others. They ensured the staff member who used the call bell system was not on their own and gave reassurance to the person concerned. Other people in the area were politely asked to move away until the situation was calmer.

Relatives told us how staff had supported them when their family members were very ill. They told us staff had been very comforting to them as well as their family members. They had been kept informed about events and felt included in discussions. Staff were described as kind, knowledgeable and treated people with dignity. One relative said, "When we come through the door we are greeted with a smile. I've developed a relationship with the staff." People told us their relatives could visit them whenever they liked. One person said, "[Named relative] can come any time they want."

We saw signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis. This ensured people could still have contact with their own families and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them.

Staff were able to explain the provider's policy on confidentiality. They understood that they could only share personal information with the person themselves or the person's advocate, unless the person was at risk of harm. Staff understood that on those occasions the information would be shared with interested parties such as the local safe guarding group and CQC.

Some people who could not easily express their wishes or did not have family and friends to support them

to make decisions about their care could be supported by staff and the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local lay advocacy service on display. There were no local advocates being used by people at the time of our visit.

Requires Improvement

Our findings

The home is split into five units and the registered manager told us people were assessed with a view of initially staying in the unit which best suited their immediate needs. As staff became more familiar with people's needs and wishes there was then opportunity for them to move to a different unit within the home. One person told us, "I was in [named unit within the home] but I've moved here now as I'm much better." However, for outside agencies assessing the appropriateness of placing people within the home, the mix of people's needs within the units was not obvious. Due to the mix of people it was hard for staff to target therapeutic interactions based on people's needs. For example, this would be different for people with mental capacity needs, physical disabilities and learning disabilities.

In the care plans we looked at the criteria for placing some people was not recorded. Therefore, it was unclear why they were at the home and if the setting was appropriate to their needs. There was a lack of a risk history for people leading up to their placements at this home. In the care plan for one person, who had complex needs we saw there had been many incidents where staff had intervened when supporting people when they became distressed. However, staff were unaware of what type of intervention had worked in the past and whether the person would require extra funding if more staff were required to monitor this person's behaviour.

Where there had been incidents where people's challenging behaviour could be harmful to themselves or others, staff had not analysed the causes of people's behaviour. For example, when a person had thrown faeces out of a window, hit their peers and threw hot water over their peers on repeated occasions. No consideration had been given to whether the person required an increase of observation or whether this had been discussed with the local authority safeguarding team. This meant staff had no means of knowing the triggers which could result in a person's behaviour and would therefore find it difficult to prevent them and others being harmed.

In the care plans there was no clear information on plans for people's health and well-being over a period of time. For example, where people had physical needs, such as mobility problems which were affecting their mental health. In one care plan we saw a person had mobility problems and could currently access their en-suite bathroom. However, they would have to access another bathroom if their mobility decreased, which they told us they would not like. The person told us they were currently 'strip washing' as they felt safer. In another care plan we saw there had been a decline in a person's memory. However, there had been no formal assessment of their needs or referral to a memory clinic.

Staff had not always recorded what actions they had taken when people were at risk of harm to themselves. For example, staff had not explored the possibility of someone who had stocked piled medicines as a possible intentional or unintentional suicide risk. The stock control records had been accurate so staff would not have known if the person had not taken their medicines or bought other medicine when they went shopping. This was potentially a high risk to that person and possibly to others if they had consumed the medicines. Staff had also failed to report whether blood levels had been taken to see if the person had already consumed any medicines. However, staff liaised with the person's GP and the medicine was removed from the person's prescription list of medicines as it was felt this was no longer required. Staff completed an assessment to ensure the person was capable of administering their own medicines and advised them how to keep them safely.

Where people could access the local community this was in their care plans. In one case a person had received support from an agency previously which gave them 'coping strategies' but this support was not in place at the time of our inspection. There were notes on the care plan that suggested this person posed a risk to themselves and others. This agency provided this intervention on a time limited basis and withdrew once this had been complete. Staff continued to provide support with these strategies, which they said were effective for that person. The person was a wheelchair user however they did respond to exercise and were hoping to regain the use of their legs. The care plan stated that the person had been prescribed exercises to do in their room but there were no notes on the file that would give us assurance that staff were supporting this person with their exercises. Following a request by staff this person has been assessed and diagnosed with a specific illness, which has opened up more avenues for a suitable placement. The person is considering those options and waiting for confirmation of a new placement.

The wording in the care plans showed the care plans were written for people, as opposed to them and their views being recorded. Staff told us care plans were to be updated every two months, but this was not so for all care plans. Two people told us they had seen their care plans, but had preferred staff to talk through the care plans with them.

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

The people we spoke with gave us positive views about the response times of staff to their needs. They told us staff responded to their needs quickly. People told us staff responded quickly when they used their call bell, day and night.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use.

People told us that staff would contact other health and social care professionals if they needed them. There was evidence in the care plans that staff had arranged visits and sought advice from a number of health and social care professionals, as well as family and friends. However, in one care plan we saw a consultant had advised that an assessment should take place in a specialist neurobehavioral unit in August 2016 and this had still not been arranged. In other care plans there was a lack of joint agency working to ensure people could access all the resources they required. This could result in people not receiving the appropriate care to meet their needs.

We were informed that an activity co-ordinator was employed for 40 hours each week and an activities worker for 25 hours each week. This ensured that social activities could take place seven days a week as the

hours were flexible. Staff told us activities were arranged through consultations and meetings with people. A programme was on display for October and we saw the advertised activities taking place. Staff said the amenities fund was very healthy and as well as raising money through discos, donations by relatives and tombola, the provider also provided resources and money. The photo album showed a number of different activities which had taken place over a period of time. The home has it's own mini bus, which made it easier for people to access local events.

Links with the local community had been encouraged. Some people went to a curling club in the local village hall and proudly showed us their named club tee-shirts. There were visits by the local scout group and local choirs. Singers, musicians, seated exercises and therapeutic sport also took place. The activities co-ordinator had also made links with a local reminiscence group to help provide stimulation for those with a loss of memory. People told us they visited the local cinema, shops, holidays and pub visits. One person was very excited about visiting a nearby large town for a shopping trip and told us, "They shops are huge, all the big name shops and very colourful." When people had specific spiritual and cultural needs staff ensured processes were put in place to allow them to access religious leaders and meet others with the same beliefs, such as going to a regular church service.

The provider had a system for managing complaints and this was available in the entrance of the service for people to access. We reviewed the complaints information and there was no record of any formal complaints having been made since July 2015. This complaint had been dealt with appropriately. There was no record kept in a central place of informal complaints or discussions about people's care that the provider could use to track trends and learning from.

Requires Improvement

Our findings

There was a registered manager in post. People and relatives told us they could express their views to the registered manager and deputy manager and felt their opinions were valued in the running of the home. One relative said, "I can go and see the manager when I want. I find her open and as a family we are confident in the way [named relative] is being treated." Staff told us they felt supported and could influence change.

Some systems for auditing and monitoring the service were in place but these were not all kept up to date. The infection control audits for the different units in the service had not been completed since 2015. There was a maintenance schedule which listed work which had been completed in 2015 and 2016. However, these works were not dated which meant that the provider could not efficiently track which would be due for renewal in line with the two yearly maintenance plan. The lack of auditing was evident in some of the fabric of the building, for example some fire doors were not working. We saw one propped open with a slipper and another one where a person living at the service was trying to fix it open and becoming distressed.

We also saw gaps in care file audits. There had not been a care file audit since April 2016. Where audits had taken place previously, again there was no system for following up any gaps or shortfalls identified and the lack of regular audits meant that the provider could not be assured that care plans reflected the current needs of people receiving care. The audits that had been completed did not effectively identify areas for improvement. For example, there was a question about whether care plans were person-centred which was answered with a tick indicating that they were. However, care plans that we looked at were lacking in information about how to support people in a person-centred way.

The provider held monthly meetings with residents to gather their views about the running of the service and the notes from the meetings showed that much of the discussion was around activities such as clubs and societies that people would like to be involved in. There was not a system for recording whether suggestions had been implemented and followed up which meant the provider could not demonstrate how effective these meetings were in influencing developments in the service. Three people and a relative told us they were not aware of meetings taking place and would therefore not be able to influence developments.

There were regular staff meetings. However, there was a risk that the language used in the minutes of these meetings may create an impression of an institutional approach to care and individuals. For example we saw notes that described some people living at the service as having 'attachment issues' and another note

reminding staff those residents were 'entitled to one to one time on an ad-hoc basis, even if this is not funded time'.

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

We saw that the results of the 2015 residents' survey had been posted on the front door to the service so that visitors could see the results and what action had been taken. The majority of options were rated as 'good' or 'excellent'. The only negative comments related to complaints and the complaints policy and the provider. All of the comments received by respondents were responded to in an open and transparent manner.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The registered manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

The provider had plans for the development of the service and was in the process of converting a bungalow on the property into flats which people could use as a step towards independent living. The manager told us that the provider was supportive and would visit the service at least once a week, spending time with them going through issues such as staffing. In addition they were working with the local care association towards resolving the issues around shortages in nursing staff and looking at a nursing apprentice scheme.

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care plans were not put together with people who used the service. They were not reviewed on a regular basis and did not reflect the needs and wishes of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality checks on the service were not robust enough and lessons learnt not passed on to staff to improve the service.