

Hamra Associates Limited

Cana Gardens Residential Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 1 and 15 December 2017, both days were unannounced.

Cana Gardens Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Cana Gardens accommodates up to eight adults with learning disabilities in one adapted building. At the time of our inspection there were 5 people living at the home.

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 there was a lack of supervision by the provider to check quality monitoring had been carried out effectively. There was an absence of quality monitoring systems which covered people's care plans and checks on medicines management.

There were no adequate infection control checks in place, staff were unsure which colour mops and buckets were used in each area of the home. Staff were also unsure what temperature soiled clothing was washed, these resulted in a heightened potential for cross infection and cross contamination of infection in the home. Improvements are required for the access to policies and procedures which would give staff the information to operate systems effectively and protect people in the home.

The systems in place were not reviewed by the registered manager to ensure people received a quality service. Incidents were recorded but information was not always sent to CQC. Improvements are required in assessing risk to people both in the home and in the enclosed garden.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. There was no system in place that allowed the registered manager to consistently supervise the staff to ensure people were safe in the home.

Health and safety checks were not regularly completed to ensure risks to people's safety were minimised. We identified some health and safety issues to the consultant manager on the first day of our inspection visit where we had immediate concerns to people's safety.

Care plans provided information for staff that identified people's support needs and associated risks. There was enough staff on duty to respond to people's health and social needs both in and out of the home. Staff recruitment procedures were adequate which ensured people were cared for by staff who had been assessed as safe to work with them.

The environment was in need of decoration, and doors were propped open which would have allowed fire to progress through the building. There was no plan of refurbishment of equipment or replacement of items or floor coverings. The main staircase carpet is in need of cleaning or replacement.

Staffing levels were adequate to ensure safe levels of care were maintained, people's health and welfare were supported and people were assisted to conduct activities in and out of the home.

People were supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's capacity had been assessed and all five people had a DoLS in place for the restriction placed on them.

Staff knew how to keep people safe from the risk of harm. People told us, and the observations we made indicated people were safe living at Cana Gardens.

People were cared for by a caring and compassionate staff group who understood people's needs, abilities, dietary and cultural requirements. Staff demonstrated their knowledge and training, however some staff training courses were out of date and we could not be assured staff were in receipt of the latest information.

Care was planned to meet people's individual needs and abilities. Staff ensured people obtained advice and support from health professionals to maintain and improve their health.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, some of these were continued breaches from our last visit. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People were at risk from harm as the provider did not ensure all areas of medication administration were operated safely. Infection control procedures were not detailed, and people were placed at risk from the potential transfer of infection. The environment was poorly maintained. Some areas were not risk assessed to ensure the environment was safe for people.

Staff were recruited safely and employed in numbers to ensure people were cared for safely.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff training was not kept up to date to ensure all staff were in receipt of the latest guidance and best practice.

Staff were aware of people's capacity to make decisions, and had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005. People were supported to maintain a healthy diet which met their cultural preferences, and their health was monitored.

Requires Improvement ●

Is the service caring?

The service was caring.

Staff were kind and compassionate, respected people's individuality and people's dignity was protected. Staff were aware of alternative communication methods and understood people's alternative means of communication.

Good ●

Is the service responsive?

The service was responsive.

People and their families were involved in planning and reviewing how people were cared for and supported. There were individual planned activity programmes that met people's

Good ●

support needs, and staff understood people's preferences, likes and dislikes. People knew how to raise a complaint.

Is the service well-led?

The service was not well led.

The systems in place to monitor the quality assurance and standards were not effective. The provider failed to identify any shortfalls and no plans were in place to look at improvements in the service.

Requires Improvement ●

Cana Gardens Residential Home

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 1 and 15 December 2017, and both days were unannounced. The inspection team consisted of one inspector and a specialist adviser. A specialist adviser is a qualified social or healthcare professional. Our specialist advisor's area of expertise was in the care of people with a learning disability.

Before our inspection visit, we reviewed the information we held about the home and information from the local authority commissioners. The commissioners for health and social care, responsible for funding some of the people that lived at the home told us they had some concerns about how the home was being managed. We took this into account during our inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the notifications from the provider; a notification is information about important events which the service is required to send us by law.

We spent time observing the care and support being provided throughout the home and in the wider community. 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 spoke with two people who lived at the home, observed three people when they went out shopping, and

others whilst in the home. We spoke with the consultant manager, senior carer and two support staff. The consultant manager works at the home and provides a training and consultancy service to the provider.

We looked at the care records for four of the people who lived in the service and the recruitment files of three staff. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

Is the service safe?

Our findings

At our last inspection in October 2016 we found improvements were needed as the provider had not ensured people were protected from the potential of cross infection or cross contamination in the home.

The provider did not send us a plan of action following the last inspection to state how and when they would address the concerns raised.

During this staff told us they had completed training courses on chemicals and control of substances hazardous to health (COSHH). However, we found the cupboard the cleaning chemicals were stored in unlocked and was accessible by anyone entering the room. There was no liquid soap in the ground floor toilet and no paper towels to dry your hands. This and other areas of the home did not have pedal operated bins to ensure infection controls were upheld. There was inadequate separation between clean and soiled linen, and staff were unaware of safe washing temperatures for soiled clothing, which placed people at risk of cross infection or cross contamination in the home.

In the dining room there was a faux leather settee. This was worn through and the fabric interior was exposed, which meant it could not be disinfected. We asked the consultant manager why a settee was placed in the dining room and he told us that staff used this to sleep on at night as there was two staff employed to remain in the home overnight, but bedroom accommodation for only one. The consultant manager said he would speak with the registered manager about disposing of the settee.

Staff were confused which colour mops and buckets were used in which area. We asked staff what temperature soiled clothing was washed on to ensure the potential for cross infection or cross contamination was reduced. They were unsure what programme should be selected on the washing machine, which meant we could not be assured that staff had the adequate knowledge to reduce the potential from infections. The colour coded mops and buckets that were stored in the laundry were not stored properly which would allow the mop to 'air dry'.

On the first floor of the home the shower room had a musty stale odour, and in the bathroom next door, there were cracked wall tiles and the bath taps had a green build-up, which required removal. People were not provided with a safe environment in which to live.

We asked staff about access to the policy and procedure on infection control and they told us they were aware they were situated in the office. However we found the policy was not detailed, and did not inform staff the correct procedures that enabled people's safety and all areas of the home were kept clean and hygienic.

We spoke with the consultant manager about how staff were trained in infection control. They said it was, "Taken care of at induction." We then asked the consultant manager for the policy and procedure for infection control. He could not find either the policy or procedure, which meant staff could not refer to the document to confirm their practice was within company guidelines.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The system to manage medicines was not always safe. We found that staff were administering most medicines in line with the prescribed amount. However for one medicine that was sent from the chemist in its original packing, there was no accurate record kept as to how many tablets had been carried over from the previous administration period. Staff were unable to confirm the person had been given the correct number of tablets. The type of prescribed medicine required regular blood tests to ensure the person received the correct dose. The provider made the GP aware of the potential error, and the GP assessed no intervention was necessary on this occasion.

We saw where a person was prescribed a short course of medicine, but there were some missing signatures on the medication administration chart (MAR). We could not ascertain if the person had completed the full course of treatment. We found where another person was on a continuing course of medicine, but staff had not signed to confirm their administration though all the tablets were missing from the blister pack.

We found the medicine trolley was not appropriately secured to the wall, and storage temperatures were not regularly recorded. We also found a bottle of pain relief medicine, which had no prescription label attached, and the contents were out of date. This placed people at risk from receiving a medicine that was not prescribed for them and was ineffective, due to the potential of the chemical compound having been altered due to age.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment of the home was in need of re-decoration and the carpet on the staircase required to be cleaned or to be replaced. There was flaking paint and bare plaster in a ground floor toilet which would not allow proper cleaning and disinfection. There was also a hole in the ceiling where a pipe had been removed, but the area had not been repaired. We were concerned about the windows in some communal areas of the home. In the main lounge and dining room the French windows were not fitting properly and you could see daylight through the gap. The low level glass did not appear to be safety glass, and so could allow someone to fall through this quite easily. We asked the consultant manager if these doors had been risk assessed, to which he replied he did not know. We were not supplied with any risk assessments at or following the inspection.

There is a pond and greenhouse situated in the rear garden of the home. We asked if the people who lived in the home accessed the area, and the consultant manager confirmed they did. The pond was not covered and the greenhouse had exposed panes of glass. Neither areas had been risk assessed and presented a danger to anyone accessing the area.

Some risks to people posed by the environment were documented and included hot water temperatures being regulated and radiators in most of the home being guarded to reduce the risk of scalds and burns. However there was a radiator in one bedroom which was not guarded. We asked for a risk assessment to ensure the risk had been assessed. The consultant manager could not find a risk assessment in the person's file.

The door into the lounge was propped open as the magnetic closer that releases automatically when the fire alarm sounds was broken. When we pointed this out to the consultant manager he arranged a call to the registered manager to have the door closer repaired. The door to the laundry was also propped open,

though had a 'fire door keep closed' sign in place. The consultant manager closed the door immediately and informed staff that this should remain closed. When we returned the second day the staff kept the door closed throughout our visit. The closer to the lounge door was still broken.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood their responsibilities to keep people safe from abuse. Staff confirmed and records demonstrated staff had received training that ensured they recognised the signs when people may have been at risk of harm. Staff said if they suspected or observed anyone being harmed they would share their concerns with the registered manager or the staff in charge at the time. One staff member said, "If I saw bruises on someone and I hadn't been told how they happened, I would ask, and if not happy would take it further." This demonstrated the staff were knowledgeable and trained to look for potential signs of abuse.

Staff were aware of whistle blowing and one member of staff told us the process they would undertake, if their initial concerns were not acted upon by the management at the service. They also knew which authorities outside the service to report concerns to, which would make sure people were protected. The registered manager was aware of her responsibilities and ensured safeguarding situations were reported through to the Care Quality Commission as required. Staff were aware of the Local Authority whistleblowing poster in the office informing them of the local contact numbers.

One person told us they thought there was enough staff to ensure people were cared for safely. Staff told us they believed that there were enough staff employed to ensure people were safe. They said there was always enough staff to take people out and provide one to one time. On the first day we visited we saw four staff take people out to their chosen activities. A support worker told us, "There are always staff on [duty] to take people out and make sure they stay safe."

The consultant manager told us they used a detailed plan of people's one to one hours, to ensure there were enough staff on duty, and someone always remained in the home in case one of the other people who used the service returned early from an unsupervised time out of the home. This information was used to provide staff cover throughout the day and night.

People's safety was supported by the provider's recruitment practices. Relevant background checks had been completed before staff commenced work at the service. Staff we spoke with confirmed they had gone through a full recruitment process, which ensured the safety of people in the home.

The number of incidents and accidents in the home was minimal, the analysis from these was used to inform staff of the lessons learnt was used to inform staff development, however was not used to ensure a safe environment.

Is the service effective?

Our findings

The staff told us they felt they were trained to do a good job. We asked how they communicated with people that were unable to use the spoken word to communicate. They told us about their induction training and the communication passports held on personal files.

However when we viewed the training matrix, we noted that some staff had not had refresher training. For example we noted that only three out of the nine long term employed staff had been trained in challenging behaviour and that was in 2012. Similarly, though eight out of nine staff were trained in infection control in 2016, staff on duty on the day were unsure of the colour coding for cleaning utensils. This is important as it specifies which utensils should be used in specific areas, to reduce the likelihood of cross infection and cross contamination in the home. That meant we could not be assured the needs of people were met consistently by a staff group who had been trained with the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours. We spoke with the consultant manager about training plans for staff, but he was not aware of any further planned staff training, and no updated training plan was sent following the inspection.

Staff told us they were supervised by senior staff. Supervision can be used for staff development and uses an exchange of information to promote change and improvements for people. They told us they could discuss changes to care plans, activities and outings and other personal development areas.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We spoke with staff who confirmed they had undertaken MCA training. However we could not be sure all the staff fully understood the principles of the Act, as some were unsure of what they could legally prevent people doing to ensure their safety. Staff were aware that people were presumed to have capacity to make decisions unless a capacity assessment was completed and proved otherwise. Staff told us, where people lacked capacity they still offered choices.

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). At the time of our inspection, one application had been approved by the local authority to make sure people's freedoms were not unnecessarily restricted.

We saw that five applications had been granted by the local authority which approved restrictions on people in the home. One member of staff told us that they had recently begun to lock the outside door to stop

someone leaving the home without an escort, though at other times the door could be accessed by people in the home wishing to leave. We looked at the person's file and saw an authorised deprivation was in place due to their poor understanding of road safety, which placed them in danger when unaccompanied out of the home.

We saw that all five people that had a DoLS in place were visited by a paid representative. They were appointed by the local authority to visit regularly and ensure that all restrictions were within the boundaries of the court order, and any positive conditions were met. Positive conditions are included in some DoLS to ensure people continued their previous lifestyle. In the case of the five people in Cana Gardens there were no positive conditions in place.

We met with one paid representative who told us staff were informed in advance of their visits, in order to ensure they visited when the person was in the home. They stated that staff were accommodating and they were provided with a private space to meet and communicate with the person. The worker told us they had no concerns over the treatment of the person they visited.

Staff were able to explain that choices were given to people prior to support being offered. For example we saw this was demonstrated by the staff asked people if they still wanted to attend a pre-arranged outing. We then saw where one person used non-verbal communication to indicate they wanted to visit a café. A number of further choices were offered by staff which ensured the person chose their preferred food and drink. A similar process was undertaken by the other people accompanying them. That demonstrated staff provided effective and meaningful choices to people.

Throughout the inspection we heard staff explaining to people and seeking their consent before they commenced a task. One member of staff said, "It's important to provide choice and gain their cooperation."

We saw that people and some of their relatives had signed consent forms for areas such as personal care, medicines, sharing information and taking photographs. Some of these had not been updated recently and it was not clear if people still had capacity to continue their agreement.

People's needs were assessed prior to them moving into the home. The consultant manager told us that a detailed assessment was necessary to ensure they could meet people's needs. This was demonstrated by the current level of staffing and provision of one to one hours, which reflected people's care and support.

People's changing needs were discussed at handover between the changes of each shift. Information was then recorded in people's daily records and when necessary used to inform and update people's care plans and risk assessments. That meant information was recorded so staff who were not on duty could update their knowledge and change their practice where necessary.

We were contacted by a professional from the local authority about the transition of a person who was moving from the home to another type of accommodation. They indicated staff were reluctant to assist the person to gather their belongings together to enable the move. We asked staff about this who said the person was offered assistance but declined. The consultant manager added that staff assisted people to move into and out of the home, and they would promote people's individual choice.

People we spoke with were happy with the quality and choice of food. One person told us if there was a choice on the menu that they didn't like staff would always prepare an alternative. Though the staff placed a weekly grocery order for delivery, staff encouraged and assisted people to go grocery shopping when additional items were required.

The menu reflected people's cultural choices, and was open to change from input with the people in the service through individual review meetings, group meetings and individual suggestions to staff. Staff were aware of people's dietary needs and provided appropriate choices in line with their diet. We saw provisions and food items that were specifically purchased for the person. These were used to provide meal choices when the person was unable to eat the same meal that others were. That demonstrated an effective staff team that met the people's individual needs.

People had annual health checks and had access to a GP and other health specialist when required such as a dentist and optician. We also saw where people had been referred by a specialist health worker for a routine appointment, this was arranged by the staff. People were supported by an effective staff team who ensured people's health care was well planned and executed.

Is the service caring?

Our findings

Staff were caring and responsive. We observed staff interactions with people throughout the inspection, which showed they were caring, helpful and respectful. Staff demonstrated patience when they supported people to allow them to maintain a pace that was comfortable for them.

Records showed that family members had been involved in care plan reviews, however these had taken place some time ago and care plans needed to be reviewed to ensure that information was up to date. We saw there was information in care plans that ensured people were referred to by their preferred name. One person was spoken with using the term referred to in their care plan. This was warmly received by the person with a broad smile anytime it was used.

Some people in the home could not communicate by word of mouth. Staff told us they were able to understand what people required by some using Makaton. Makaton is a language programme using signs and symbols to help people to communicate. Makaton was designed to support spoken language and the signs and symbols can be used with speech, in spoken word order. We saw others in the home using pictorial signs to make choices. We also observed one person who communicated by individual sounds. Staff were immediately aware what the person required, and provided the appropriate assistance, accompanying the person to support them throughout the process.

We saw that there was information regarding independent advocates available at the service. An advocate can assist people who have difficulty in making their own, informed, independent choices about decisions that affect their lives. We discussed advocacy with the consultant manager who was aware of one person who had used this service, and was also aware of the paid representatives who visited people on behalf of their DoLS restrictions.

Throughout our visit we saw that people were able to make choices about how and where they spent their time. We observed staff knocked on people's bedroom doors before entering which meant staff recognised and respected people's privacy and dignity. We observed people were spoken with respectfully throughout our visit.

Staff we spoke with told us they encouraged as many people as possible to maintain their independence as long as they were safe to do so. Staff gave an example where they would observe a person that did not communicate by word of mouth. At times they would go to the shower room, which indicated they wanted a shower, staff would ensure the room was safe and water temperature was adjusted, and then left the person in private to shower. These instructions were mirrored in the persons care plan. Throughout our visit, we saw staff encouraged people to make their own decisions and prompted them to move around independently.

Staff respected people's dignity. For example we saw a person being prompted for personal care prior to going out into the community. Staff prompted the person by the prompt in the care plan, and we heard staff give clear instructions to the person and allowed them to proceed at their own pace. We observed care staff interacted well with people, and read their body language and responded positively to the prompts

assisting people when necessary.

Is the service responsive?

Our findings

People were cared for and supported in the way which reflected in their care plan and met their individual needs.

Staff demonstrated they were aware of people's individual needs, and were aware of people's preferences and allergies. For example staff were aware of the individual communication a person presented when they required some personal and individual attention.

We saw that people were supported to continue with their love of music, and their well-proportioned room was set out with their music player and a large variety of cd's. They told us they liked visiting second hand shops to purchase other cd's. They were also supported to continue their education at a local college.

We saw others that were more dependent on staff for their support. Staff explained even though people were reliant on them it was part of daily life to, "Encourage people to do even little tasks for themselves, it doesn't matter how long it takes." They went on to explain a person with restricted mobility was able to mobilise in the home but was less able when out of doors. They further explained that rather than relying on a wheelchair for distances, they planned the trip out of doors by staff assisting the person, and then seeking rest stops along the way. Although this took longer, it provided the person to retain a level of fitness, that then helped them access all of the ground floor in the home.

People had a planned activities programme in place which reflected their one to one assistance.

We spoke with the consultant manager about the provision of activities in the home. They said the staff supported some group activities, such as special 'carry out' meals and film nights, but the majority of people's activities were based around their individual needs. That demonstrated the provider provided a responsive staff group that provided person centred care.

Care plans detailed and had been recently reviewed. Pre-admission assessments were in place and care planning was linked to people's individual needs. There was evidence of an up to date photograph, in most people's files, which was necessary in people's files in case of emergencies. We spoke to the consultant manager who stated he would have an up to date photograph arranged. There was also information about people's past history, allergies, likes, dislikes, wishes and aspirations and these were incorporated into the care plan to support care delivery. Communication passports were in place, and staff were aware of these and access to the care plans anytime they required. Communication passports are a means of communicating people's support needs, where the person is unable to express those needs verbally or has a cognitive impairment that reduces their ability to communicate. Staff were able to explain and demonstrated through the care we observed the support that people required.

Care plans showed evidence of using advocates. For example this was where on person was being introduced to residential care. The advocate was involved through a recommendation from the DoLS team. An advocate can assist people who have difficulty in making their own, informed, independent choices

about decisions that affect their lives.

We asked the consultant manager about how the accessible communications standards have been introduced to the staff group. The accessible communications standards allow staff to formally recognise, assess and record the communication needs of people who have been affected with a hearing and /or sight loss, or communication debility caused by a life changing event. The consultant manager was not aware of, nor had instructed the staff in the five steps within the assessment process. That meant people's accessible communication needs had not yet been introduced as part of a holistic assessment process. However we found one person was using pictorial cards to communicate on days when their vocal abilities had been affected. We were also aware of and saw people who communicated with staff using the Makaton signing system. When fully implemented this should enable individual and responsive communication between people in the home and entire staff group.

We found people were offered support that met their cultural and dietary needs. One person told us, "I like the food they take me out for meals too."

We spent time and observed all of the people who lived in the home, at different times of the day and both within the home, and when people were out shopping. People remained relaxed and at ease with the staff group, which would indicate they knew the staff well and responded to the relaxed atmosphere.

When we spoke with one person they told us they were happy. One person said, "[I am] happy here, I get to go out, I have no complaints, [if I did I] would speak to staff."

The provider had systems in place to record complaints. Records showed the service had received no written complaints in the last 12 months. The consultant manager said feedback about complaints was provided for staff through planned staff meeting or individual supervision. We looked at the complaints policy and procedure, which included details of the local authority, which are the appropriate body to investigate complaints.

We saw that one person had a care plan in place for the period when they reached the end of their life. We discussed the other people in the home with the consultant manager, who said they would seek people's views and ensure plans were put in place where people agreed.

Is the service well-led?

Our findings

During our last inspection in October 2016 we found improvements were needed as the provider had not notified us, without delay, of an allegation of abuse in relation to a service user and an incident which was investigated by the police.

The provider did not send us a plan of action following the last inspection to state when they would be compliant.

At this inspection we found there was some improvement where we had been sent information on most of the incidents that affected people in the home. However we were not sent information about an incident involving a member of staff that resulted in significant disciplinary action.

This was a continued breach of Regulation 18 (Registration) Regulations 2009, Notification of incidents.

During our last inspection in October 2016 we found improvements were needed as the registered provider had not ensured that systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the service provided or to monitor and mitigate the risks relating to the health, safety and welfare of service users.

At this inspection the provider had appointed a number of people who were responsible for the day to day running of the home, as the registered manager was on holiday when we inspected. There continued to be an ineffective system of internal audits and checks completed to ensure the safety and quality of service was maintained.

The provider had not completed a thorough infection control audit. There were infection control issues, with a lack of soap, towels and proper waste bins. There were areas that were unable to be cleaned or disinfected properly, and staff were unsure of the appropriate cleaning products and materials to be used in certain areas of the home, and adequate washing temperatures. There were areas of the home that were not secure and cleaning chemicals were accessible by anyone living in the home. These areas could have been revealed and addressed had audits of the environment and infection control been undertaken.

Medication audits had not been undertaken since we last inspected. We found a number of issues with the medicines system which included poor record keeping, missing signatures on medication administration charts (MAR), and an absence of regular storage temperatures. These issues could have been addressed if a thorough audit of the medicines system had been undertaken.

There were no regular or consistent checks on the environment. There was no available plan of redecoration or refurbishment of the property. There were areas both inside and outside the home which had not been properly risk assessed, which resulted in a significant danger to anyone accessing the outside area if unescorted. Fire doors were propped open which presented danger to people in the event of a fire.

The policies and procedures did not provide staff with the guidance and instruction to keep people safe or operate processes in the home.

The staff training matrix was not up to date, nor was there a clear staff development plan to ensure staff training was planned.

These were a serious failure by the provider to use any adequate governance processes which could have revealed these errors and omissions.

The provider lacked the insight into ensuring the safe and effective running of the home, which impacted on the quality and safety of the service offered. Quality assurance and governance were not used effectively to drive continuous improvement in the home.

This was a continued breach of Regulation 17(a) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager at the service at the time of our inspection visit, who was also the companies nominated individual. The registered manager did not work at the service each day. The home continued to be run on a daily basis by a consultant manager, deputy manager and senior staff.

We asked staff about the consultant manager and other senior staff that ran the home in the absence of the registered manager. Staff told us they worked well as members of the team, and were aware of the registered manager who visited occasionally. One support worker commented "It's a nice home to work in, small like a family, a good place to work."

We spoke with the consultant manager about the provider's vision and values. They said they were unsure about the vision and values, but there was the statement of purpose in place which provided some information. The consultant manager explained there had been two recent staff meetings, the latest of which he had not attended. These were used to communicate changes to the staff and were part of the provider's vision and values where they openly discussed changes to people's care and support. When we spoke with staff they were unaware of the provider's vision and values. This does not support a culture where there is a clear vision from consistent and effective leadership which achieves good outcomes for people.

Staff were aware of and information was posted in the office about whistleblowing, which was also discussed regularly at staff supervision and meetings.

The consultant manager told us he was not aware of any quality assurance questionnaires that had been sent to people who used the service or their relatives. He did say they operated an open door policy, where they would speak with anyone who had any issues.

Prior to our inspection visit we contacted the health care professionals involved with the people who used the service. The local authority continued to monitor the home to ensure people placed there received a good service.

This section is primarily information for the provider

Action we have told the provider to take

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

| Regulated activity | Regulation |
|--|---|
| Accommodation for persons who require nursing or personal care | <p>Regulation 18 Registration Regulations 2009 Notifications of other incidents</p> <p>There were inadequate systems and processes to enable the provider to notify us, without delay, of an incident involving a member of staff that resulted in significant disciplinary action.</p> |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | <p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>There were inadequate systems and processes to enable staff to safely administer medicines. Checks were not in place to ensure prescribed medicines were administered properly.</p> <p>There were inadequate systems and processes to enable staff to ensure the safety of people and guard against cross infection and cross contamination in the home.</p> <p>There were inadequate systems and processes to enable staff to ensure the safety of people by having in place risk assessments to reduce and mitigate the risks.</p> |