Sterling Care (Uk) Ltd

Highfield Residential Care Home

Inspection report

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Date of inspection visit:
15 May 2018
17 May 2018
21 May 2018

Date of publication:
03 August 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Highfield is a 'care home'. People in care homes receive accommodation and 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. Highfield accommodates up to 20 people, some of whom may be living with dementia, in one adapted building. At the time of our comprehensive unannounced inspection on 15,17 and 21 May 2018 there were 16 people living in 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. The registered manager was also the provider. For the purposes of this report they have been referred to as the provider.

We had previously inspected the service on 9 and 10 August 2017. We found that the provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of seven regulations including person-centred care, dignity and respect, need for consent, staffing, safe care and treatment, meeting nutritional and hydration needs and good governance. The overall rating for the service was inadequate.

Following our previous inspection in August 2017, the provider sent us an action plan stating that they would make improvements by 30 November 2017. In addition to this, we issued a Notice of Proposal to impose conditions on the provider's registration because they had failed to make any improvements in relation to three of the regulations. These included safe care and treatment, meeting nutritional and hydration needs and good governance. As a result, the provider was required to send us a range of monthly monitoring reports.

During this inspection, we found that the provider was in breach of seven regulations. You can see what action we told the provider to take at the back of the full version of this report.

The provider had failed to comply with a number of the regulations as required under the HSCA 2008 (Regulated Activities) Regulations 2014. In addition, the provider had consistently failed to sustain improvements where breaches of regulations had been identified during previous inspections.

The provider was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks within the environment were not managed and mitigated. Individual risks to people were not appropriately assessed and managed. Accidents and incidents were not recorded appropriately and staff did not always complete follow up actions after an accident. People's medicines were not managed in a safe way and staffs' competency in this area was not regularly assessed.

There were not sufficient numbers of staff to support people in a safe way that met their care and support

needs. Therefore, the provider was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dignity was not always upheld and people told us that staff did not always treat them in a caring manner. Therefore, the provider was still in breach regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people lacked the mental capacity to make a specific decision, the provider had not made sufficient improvements to act in accordance with the requirements of the Mental Capacity Act 2005. Decisions which needed to be made in people's best interests were not documented. Therefore, the provider was still in breach regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans and risk assessments were not detailed and gave conflicting advice about people's care and support needs. This meant the provider was still in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of effective systems in place to monitor and assess the level of service being delivered. This meant the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not adequately trained to carry out their role. Not all staff had completed their training as stipulated by the provider. However, staff received regular supervision with either the deputy manager or the provider.

Staff understood their responsibilities in relation to safeguarding and knew how to report any concerns and to whom. There were processes in place which helped to ensure that suitable staff of good character were employed.

We found that sufficient improvements had been made with regards to providing person-centred care, treating people with dignity and respect and meeting people's nutrition and hydration needs.

There was a range of activities for people to take part in and people were cared for in an empathic manner.

Staff morale had improved and they understood their roles and responsibilities. There was clear leadership in the home and the deputy manager operated an open-door policy.

At this inspection we found there had been insufficient improvements made and some improvements had not been sustained. This resulted in the service being rated inadequate in safe and well-led.

The overall rating for this service is inadequate. Therefore, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not managed in a safe way.

There were not enough staff to care for people to maintain their safety.

Individual risks to people were not adequately assessed or mitigated.

Risks within the environment were not managed and mitigated.

Staff understood what constituted abuse and how to report any concerns.

The home was clean and staff knew their responsibilities in relation to infection control.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not act in accordance with the Mental Capacity Act (MCA) 2005 and best interests decisions were not documented.

Staff had not completed all of their mandatory training.

People were supported to maintain a healthy nutritional intake.

Referrals to other healthcare professionals were made when there were concerns about a person's health or wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always upheld and people's belongings were not consistently treated with respect.

People's independence was not always promoted.

People were able to have family and friends visit without restriction.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records lacked sufficient detail and were not person-centred.

There was a range of activities for people to take part in.

There was a complaints procedure in place and people felt able to make a complaint.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of robust systems in place to monitor and assess the quality of service being delivered.

There was a failure to maintain up to date records about people and rectify concerns within the environment.

There were regular meetings for people living in the home and staff.

Staff morale had improved and they felt supported in their role.

Highfield Residential Care 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 unannounced inspection was carried out on 15,17 and 21 May 2018 by one inspector, a medicines inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete 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 received a completed PIR from the provider. We also looked at information we held about the service, including statutory notifications. A notification is information about important events, which the provider is required to send us by law.

During the inspection we spoke with six people who lived in the home and one person's visitor. Some people were not able to tell us about the care they received so we made observations of the care and support people received at the service throughout the day. We also spoke with the registered manager, the deputy manager, the administrator, two members of care staff and the cook.

We reviewed three people's care records and medicine administration record (MAR) charts. We looked at three staff recruitment files as well as training, induction and supervision records. We also viewed a range of monitoring reports and audits undertaken by the deputy manager and the administrator.

Inadequate

Is the service safe?

Our findings

At our last inspection in August 2017 we found that the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not always managed or administered in a safe way and there was no system in place to evaluate practice in this area. They were also in breach of this regulation because individual risks to people's health and welfare were not managed and mitigated. Risks within the environment of the home were not adequately monitored.

Following our inspection in August 2017, we imposed conditions on the provider's registration. This meant that the provider was required to send us monthly reports showing how they managed and mitigated risks relating to the safe care and treatment of people. Whilst information was received in a timely manner, the reports did not always detail how individual risks were managed. For example, risks in relation to pressure care were not reviewed.

We found during this inspection on 15, 17 and 21 May that there were still concerns around the safe administration and management of people's medicines. Action had also not been taken to ensure that individual risks to people were identified and managed. We also found that environmental risks were not mitigated. We concluded that the provider was still in breach of this regulation.

Records were in place for medicines with prescribed instructions. We noted that there had been two medicines that had recently not been given to people because they were unavailable and not obtained in time to ensure their treatments were continuous. In addition, there were gaps in records for medicines prescribed for external use such as creams and ointments where records did not confirm they had been applied as intended by prescribers. We found there had been no recent medicine-related incidents logged and investigated by the management.

Some supporting information was available for staff to refer to when handling and giving people their medicines. There was information about people's known allergies and medicine sensitivities but personal identification was missing for some people to assist staff to ensure they gave people their medicines safely. Information about how people prefer to take their medicines was not sufficiently detailed to be person-centred.

When people were prescribed medicines on a when-required basis, including pain-relief and sedative medicines there was not always written information available to show staff how and when to give the medicines to people to ensure they were given consistently and appropriately. For example, for two people prescribed sedative medicines on this basis there was no written information for members of staff to refer to. Records showed these medicines were being given regularly each day but there were no records showing why the medicines were needed or that justified their use so they may not have been given appropriately.

For people prescribed external medicines such as creams and ointments there was not always detailed information showing where on the body the medicines should be applied. We also noted that containers of

external medicines were not handled in a way that would indicate, once opened, when they would expire and so ensure they were still safe for use.

We found that some medicines including both oral and external medicines could be accessed by non-authorised persons and were not stored securely for the protection of people who used the service. In addition, the medicine refrigerator temperature records indicated that medicines requiring refrigeration had not been consistently stored within the correct temperature range so may no longer be safe for use.

Staff authorised to handle and give people their medicines had received training. However, whilst they had been assessed by community nurses as competent to give people insulin by injection, they had not recently been assessed as competent overall to give people their oral medicines.

Individual risks to people were not managed and mitigated sufficiently. One person showed behaviour that challenged and their risk assessment stated that they were prone to 'violent outbursts'. Their care plan was evaluated on 30 March 2018 and this stated that they were still showing behaviour that challenged. This person was sharing a bedroom with another person. There was nothing in the risk assessment regarding how risks to other people could be managed and if they were suitable to share a room with another person.

Risks relating to people choking were not managed safely. We saw from one person's risk assessment that they were at risk of choking and that they required constant supervision from staff while they ate their meals. On all three days of our inspection we saw that this person did not have constant staff support to eat their lunchtime meal. We also noted that they were not sat in an upright position which would minimise the risk of choking. There was nothing in the person's risk assessment to detail what staff could do to minimise this known risk.

Some people were at risk of developing pressure ulcers. The deputy manager told us that no one living in the home required repositioning as they all had appropriate pressure relieving equipment in place. We checked this and observed people who were at risk were sat on pressure reliving cushions and some people had pressure reliving mattresses. However, regular repositioning of people was still required to reduce the risk of developing pressure ulcers

Throughout the inspection, we observed some people to be sat in the same position for a number of hours without being repositioned. One person was unable to clearly communicate their needs to staff. We noted from one person's pressure ulcer risk assessments that they sometimes developed redness due to their sitting position. We noted that this person would often sit in a way that was not conducive to maintaining the integrity of their skin. There was also no guidance in the person's risk assessment to detail how staff could promote a better seating position.

Risks in relation to falls were not managed sufficiently. One person had fallen out of their bed twice in the space of three days. Both falls necessitated a hospital admission. When the person returned after the first fall, nothing had been put in place to mitigate the risk of this happening again. A second person had fallen twice after trying to use their commode during the night. No follow up action was taken in relation to these falls, for example, checking the person every few hours after their fall to ensure they were not experiencing any pain.

Risks within the environment were not mitigated. Records we looked at showed that the hot water cylinders were not storing water at the required 60 degrees centigrade. It is important for hot water to be stored at this temperature to minimise the risk of legionella bacteria developing in the water system.

Records relating to fire safety showed that some automatic door closures on a number of doors, including people's bedrooms, were not working. The closure on one person's bedroom door had not worked for at least two months. We noted from this person's care records that they liked to sleep with their door open at night. This meant that people were not fully protected in the event of a fire.

As a consequence of these findings, the provider was still in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in August 2017 we found that the provider was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not sufficient numbers of staff to meet people's needs.

Following our inspection in August 2017, an action plan was submitted by the provider which detailed how the service would meet the legal requirements. They told us that this would be completed by 30 November 2017.

We noted there had been some minor improvements here but we remained concerned that there were not enough staff to meet people's needs. Two people we spoke with told us that they had soiled themselves because they had to wait for staff to support them to use the toilet. One person told us, "I ring my bell but it doesn't work although [the staff] say it does. It takes about half an hour for [the staff] to come, they say they are busy."

A number of people required the support of two staff for mobilising and their personal care needs. There were only three staff working during the day. All of the staff we spoke with told us that they found it difficult to see to people's care needs in a timely manner due to the low numbers of staff. Staff we spoke with also confirmed that they have not been able to get to people in time to assist them to use the toilet. The provider did assess people's dependency but staff reported that more staff were needed at busier times such as the mornings.

There were times where staff were not always present in the communal areas of the home. This was more evident in the mornings. People in these areas did not have access to a call bell so they could summon assistance quickly. On the first day of our inspection one person summoned a member of the inspection team as they were concerned for another person in the lounge.

As a result of these findings, the provider remains in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we had some concerns about the action taken after a person had fallen, we did see that action had been taken in response to other accidents. The deputy manager wrote a monthly summary of accidents and incidents. We saw from these records that action was taken to mitigate the risk of future falls. The audits did not give the times and locations of all of the falls, therefore, no analysis was carried out to identify any patterns or trends.

Staff understood their responsibilities in relation to safeguarding. Staff we spoke with knew what constituted abuse and how they would report any concerns. They also knew which outside organisations they would speak with if they suspected someone was being abused. The staff we spoke with told us they had received training in safeguarding and records we looked at confirmed this. However, we noted that only nine members of staff had received training in this area. This meant that there was a risk that all staff did not

have the required knowledge in this area.

There were safe practices around the recruitment of staff. Appropriate references had been sought and a satisfactory check from the Disclosure and Barring Service (DBS) had been obtained before staff started working at the service. A DBS check is a criminal records check. These checks helped to ensure that people were of good character before they were offered employment.

The home was generally clean throughout and staff wore disposable aprons and gloves when attending to people's personal care needs or handling food. We saw that the kitchen was clean and we saw that a daily cleaning schedule was completed by the cook. The home had a food hygiene rating of five. This is the highest rating and means that the food standards in the home are very good.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in August 2017 we found that the provider was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because mental capacity assessments were not carried out and staff did not act in accordance with the requirements of the Mental Capacity Act 2005 (MCA).

Following our inspection in August 2017, an action plan was submitted by the provider which detailed how the service would meet the legal requirements. They told us that this would be completed by 15 November 2017.

At this inspection, we noted that some improvements had been made but further improvements were still needed. The provider remains in breach of this regulation.

The MCA 2005 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The service did not always act in accordance with the principles of the MCA. Some people lacked the capacity to make decisions for themselves and required staff to make decisions in the best interests. There was nothing in people's care records to show what decisions needed to be made in their best interests and why these decisions needed to be made.

The provider had also installed Closed Circuit Television (CCTV). There were a number of cameras around the home, all of them situated in the communal areas. There was a lack of information given to people with regards to this. The consent for this was added to the consent to care and treatment form, which did not provide details about the use of CCTV and how peoples data would be protected. We also noted that where people lacked the capacity to consent to the use of CCTV, consent had been obtained by relatives or friends who did not have the authority to consent on the person's behalf.

People or other's acting on their behalf were not asked for their consent about sharing a room with another person. We looked at the care records for two people who shared a room. There was no documentation to show that either person had consented to this.

As a result of these findings, the provider remains in breach of regulation 11 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us how they obtained consent before providing care to people. During our inspection we saw on a number of occasions that staff asked people if they needed any support before helping them. For example, we saw one member of staff asking one person if they would like any support with eating their lunch.

We looked at training records and noted that the provider had devised a comprehensive list of mandatory training for all staff to complete. Training courses included moving and handling, fire safety and pressure care. Training was delivered using a variety of formats such as face to face and online.

Not all staff had completed the required training as stipulated by the provider. This meant that there was a potential risk that staff did not have the required knowledge to carry out their role effectively. The provider told us that they had tried a number of ways to encourage staff to complete their training. Staff were also able to use the IT facilities in the service and seek support from the deputy manager if they were unsure about completing their online training.

Staff received regular supervision with either the provider or the deputy manager. Staff we spoke with confirmed that they had received supervision and that they found these meetings to be supportive in nature. New staff had supervision within a few months of them starting in their new role to reflect on how they were finding their role and to address any further training needs.

For new staff, there was no formal induction process in place. The provider told us that they were developing an induction programme for new staff. Whilst there was no formal induction in place, new staff would shadow a more experienced member of staff until the deputy manager feels they are competent to work without supervision.

The provider and the deputy manager requested assessments of people's care and support needs before it was agreed if the service was the right place for the person to live. We saw that that assessments of people's needs were provided by the local authority or via the 'Trusted Assessor Scheme'. A Trusted Assessor is a professional who will assess a person awaiting discharge from hospital either back to their home or to another setting. This process enables people to move to a more suitable environment without any delay.

At our previous inspection in August 2017 we found that the provider was in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks relating to people's nutritional and hydration needs were not effectively managed. People were not supported to maintain a healthy nutritional intake according to their dietary needs or preferences.

Following our inspection in August 2017, we imposed conditions on the provider's registration. This meant that the provider was required to send us monthly reports showing how they managed and mitigated risks relating to people's nutritional and hydration needs. At this inspection in May 2018, we found that improvements had been made and the provider was no longer in breach of this regulation.

We received mixed feedback from people when we asked people about the quality of the food. Two people we spoke with told us that the evening meal was small and that they were hungry in the evening. Other people we spoke with were complimentary about the quality and quantity of the food at meal times. One person explained, "[The food] is lovely, some of it is better than a restaurant." A second person told us, "The food is very good, particularly lunchtime."

We observed the lunchtime meal being served and the food looked appetising and people were offered second helpings. People were served their meal in order of their room number. This meant that some people who decided to have their lunch in the lounge were served their meal when others had nearly finished theirs.

Where there were concerns about a person's nutritional intake, we saw that referrals had been made to the relevant healthcare professionals. During our inspection, we saw that people were served meals which were prepared according to their individual needs. The cook had a good understanding of people's individual preferences and nutritional requirements. They told us that if people's dietary needs changed, then these were communicated quickly by care staff.

People were supported to access healthcare professionals when needed. One person we spoke with told us how they were able to see a GP when they requested and that they received regular visits from the chiropodist. We saw during our inspection that staff passed any concerns to the deputy manager about people's health needs. The deputy manager then contacted the relevant health care professional.

There were processes in place to ensure that information about people's care needs was shared in a prompt manner with other healthcare professionals. For example, when people needed to go into hospital, a document called 'This is Me' was given to healthcare staff. This contained detailed information about people's healthcare needs and their preferences about how they liked their care to be given.

The service was adapted in some areas to meet people's needs. There was access to a courtyard garden, and there was signage to the communal areas of the home. There was some personalised signage on people's bedroom doors, but some people's doors lacked any clear signage. By having rooms and different areas clearly marks helps people to maintain their independence when moving around the home independently.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in August 2017 we found that the provider was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's dignity was not always preserved and personal information was not always treated confidentially.

Following our inspection in August 2017, an action plan was submitted by the provider which detailed how the service would meet the legal requirements. They told us that this would be completed by 30 November 2017.

Whilst we still had concerns about people's dignity being upheld, and the provider remained in breach of this regulation.

We received varied feedback when we asked people if they were treated in a caring and respectful way. One person told us, "[The staff] usually [talk to me in a nice way] sometimes not." A second person explained, "I try to consider [the staff] but they don't give you credit for it." Other people we spoke with were complimentary about how caring the staff were. One person commented, "[The staff] don't talk to me like I'm an idiot." One persons' visitor told us, "I think the staff are exceptionally kind."

People's dignity was not consistently upheld. We saw a number of females with facial hair and some men's facial hair looked unkempt. Some people's hair looked like it had not been washed. Another person had fallen asleep in their breakfast and a member of the inspection team had to summon a member of staff to help wake the person.

One person we spoke with told us that they had moved rooms several times and that the pictures they had displayed in their previous room were screwed up in a drawer. We could not be assured that people's belongings were always treated with respect.

People were not always given a choice about how their care was delivered, for example, some people preferred to have a shower but we saw from their personal care records that they were always given a body wash on their bed. We saw a number of people were sat in the same place all day and we did not observe staff checking with people if they were happy where they were.

These findings constitute a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout our inspection visit, we observed many examples of people being spoken to and treated in a kind and compassionate way. We saw staff transferring one person to a wheelchair. Staff were patient and explained to the person what they were doing as they supported them to their wheelchair. Staff were patient when supporting people to move around the home and would hold people's hands to help guide them to where they wanted to be. Staff used this time to engage people in conversation.

Staff were able to tell us how they offered people choice, but some people were unable to make choices for themselves. We did not see communication aids such as pictures to help people to make decisions. For example, the choices for lunch were written on a blackboard, but there were no pictures to show people what the meal looked like.

People were not always supported to maintain their independence. We saw one person who experienced difficulty with their meal because there was no plate guard on their plate. This adaptation would have promoted the person's independence with eating their own meals. However, we did see examples where people were supported to maintain their independence. Some people had mobility aids which enabled them to move around the home independently. A member of staff told us how one person was able to dress themselves in the morning but staff would go and ensure that they had managed to put certain items of clothing on the right way.

People were able to have family and friends visit with minimal restriction. One person told us, "I have friends and family, they visit twice a week." There was a small conservatory that people could use if they wanted more privacy.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in August 2017 we found that the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's treatment was not personalised in order to meet their needs. People's care was not reviewed and people's preferences for their care and treatment were not documented.

Following our inspection in August 2017, an action plan was submitted by the provider which detailed how the service would meet the legal requirements. They told us that this would be completed by 17 November 2017.

Improvements had been made, however, further work was required in relation to ensuring that people's care and treatment needs were fully documented. Therefore, the provider remained in breach of this regulation.

People's needs were not responded to in a timely way. One person became distressed easily and would spend time walking around the communal areas. At times this would upset other people. There was nothing in their care plan to show how staff could minimise any upset that the person caused other people could be minimised. However, when staff were available, we saw that they used distraction techniques and successfully engaged the person in an activity or conversation.

People's care plans and risk assessments did not always contain a sufficient amount of detail regarding their individual care needs and their preferences about how they wanted their care delivered. For example, one person's care plan stated that they preferred to have a shower. We saw from their personal care record that they were not given a shower. We asked the deputy manager about this and they told us that this was because there was not a shower chair suitable for the person. They added that they would look into ordering one which would accommodate the person so they could have a shower.

Some people's care plans gave conflicting advice. We saw from one person's medicine usage care plan that they were taking some medicines. We then noted that their falls risk assessment stated that they were not on any medicines. A second person's care plan around their end of life care stated that they did not have a do not attempt resuscitation (DNAR) decision in place, however there was a DNAR form in their care records.

These findings constitute a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us that they were working on improving the quality of people's care records and this was an ongoing process. We saw some examples of detailed guidance about people's individual care needs. For example, one person could eat independently most of the time, but on some days, they required support from staff. We saw during our inspection visit that this person was supported with their meals when needed.

Since our last inspection, a new activities coordinator had been appointed. We saw people engaging in a range of activities during our inspection visit. One morning people were having their nails painted and on one of the afternoons people could join in with karaoke. We saw many people joining in and the staff also sung along too. The activities coordinator told us that they were supported by the provider to obtain different materials for arts and crafts and they were given time to take people to attend local Church services.

There was a policy in place for dealing with complaints. People we spoke with told us that they knew who they would raise any complaints with. The provider told us that they had not received any complaints since our last inspection in August 2017.

People's preferences for their end of life care were not clearly documented. We noted that one person's end of life care plan stated that they were 'dying from old age.' The care plan also failed to document the person's preferences about their care at the end of their life and any religious or spiritual beliefs they would like to be taken into account.

Inadequate

Is the service well-led?

Our findings

At a previous inspection in October 2016 we found that the provider was in breach of four of the regulations. A further inspection in August 2017 we found that the provider was in breach of seven of the regulations, this included repeated breaches for three of the regulations, including regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because suitable systems were not in place to monitor, assess and improve the quality and safety of the service. Accurate and complete records were not maintained in respect of each person who used the service.

Following our inspection in August 2017, we imposed conditions on the provider's registration. This meant that the provider was required to send us monthly reports showing how the quality of service delivered was monitored and assessed.

We found during this inspection in May 2018 that there was still a lack of effective quality monitoring systems in place to monitor and assess the safety of people and the quality of service being delivered. We concluded that the provider was still in breach of this regulation.

Audits of people's medicines remained ineffective. These failed to identify that there was a lack of person-centred information about how people liked to take their medicines. In addition to this, the audits failed to identify gaps in people's Medicine Administration Record (MAR) charts and that staffs' competencies in administering people's medicines had not been assessed.

Daily health and safety checks were carried out and we noted that a number of issues were identified. For example, we saw that two light bulbs were not working in the hallway. This took three weeks to be fixed. Poor lighting posed a risk to people moving about the home due to poor visibility. We also noted that the health and safety checks identified that there were loose tiles around a person's sink. We noted this issue had been identified on at least six occasions and the provider failed to take action. This meant that people were at risk of hurting themselves on the loose tiles.

Fire checks had identified that some of the door closures on people's door were not operating properly. The provider had not done everything practicable to repair the door closures, leaving people at risk in the event of a fire. These concerns were reported to the local fire officer. Risks relating to legionella had been identified but again, no action was taken.

The provider did not have a comprehensive action plan in place which identified all of the known safety concerns and how they planned to address these, and by when.

People's care plans were not audited by the provider to ensure that they were person-centred and contained the most current information about people's care and support needs.

We still remained concerned that the provider did not maintain a thorough oversight of the service through regular monitoring and assessment of the level of service being delivered.

As a result of these findings, the provider remains in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in August 2017, we were concerned that the provider was not always at the service. This was because they were also the registered manager and there was a lack of leadership within the service.
At this inspection in May 2018 we found that whilst there were long periods of time when the provider is not present, they had regular communication with the administrator who provided them with a daily report about any significant events.

A deputy manager had been recruited since our previous inspection. This meant that there was a senior member of staff in place to oversee the day to day running of the service. They had worked at the service before and also had experience of working in similar services. We saw that the deputy manager operated an open-door policy and we saw people who lived in the home approaching them for a chat and staff we spoke with told us that they felt able to speak with the deputy manager.

The deputy manager stated that they wanted to take on more responsibility, such as supervision of staff. They told us that it would be more appropriate for them to do this as they managed staff on a day to day basis. They added that the provider was happy for them to do this. This meant that staff would be supervised by a manager who regularly observed them in their work and who had a good understanding of the day to day tasks staff are required to complete.

Staff we spoke with told us that that felt happier working in the home since the deputy manager was employed. They added that there was clear leadership in place and they felt comfortable raising any concerns they had with them. We noted during our inspection visit that the atmosphere in the home was calmer and the staff communicated changes in people's needs quickly to other team members and the deputy manager. All of the staff we spoke with told us that morale within the team had improved.

There were regular meetings for people who lived in the service. One person we spoke with told us, "[The provider] has these meetings. In these meetings he says [any problem] small or big, come and tell me about it, this is your home." The meetings gave people the opportunity to become involved in how the service was run and put forward any suggestions for improvements. Meeting records we looked at showed that people were asked about their suggestions regarding activities provided and food they would like to see included on the menu.

The provider did not have an annual comprehensive survey in place to seek feedback from people, their relatives or visiting health professionals about the service provided. The deputy manager told us that there was a suggestion box in place but it was rarely used. They told us that they would look at ways of encouraging people to use this facility. They added that they were looking at implementing a satisfaction survey for people and their relatives in the future.

Staff also attended regular meetings where they discussed people's care needs and training that staff were expected to complete. Staff we spoke with were positive about the meetings. One member of staff explained, "We have staff meetings about once a month and they are useful. It gives us time to ask or raise anything."

The provider and staff working in the service worked with other agencies to improve the quality of the service. The provider had been working alongside staff from the local quality assurance team and safeguarding to improve the quality of service being delivered.