Oakleigh Lodge Residential Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Oakleigh Lodge Residential Home is situated in Hove, East Sussex. It is a residential 'care home' for up to 15 older people some of whom are living with dementia. At the time of the inspection there were 14 people living in the home.

People's experience of using this service and what we found
Risks were not well-managed, and some people had been exposed to increased risk of harm. There was a lack of oversight of risks to some people's care. Insufficient guidance was provided to staff to inform them of some people's needs. Medicines management was not always safe. Staffing levels at night were not safe and were not aligned to people's assessed levels of need. There were concerns about some people's safety and being provided with effective care due to some staff's lack of training. Fire safety had not always been considered and this increased the risk that people would be exposed to risk of harm. We made three safeguarding referrals as well as a referral to East Sussex Fire and Rescue Service following the inspection.

There was a lack of oversight and the provider had not made enough improvement since the last inspection to ensure the quality of care met people's needs. Quality assurance systems were not always effective and had failed to identify the shortfalls found at the inspection.

People were not always supported to have maximum choice and control of their lives and staff had not always supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We recommended the provider sought further guidance in relation to the mental capacity act and associated codes of practice to ensure people were effectively supported with decisions when they had a condition that had the potential to affect their decision-making abilities.

Plans were in place to further involve people in the planning of their care and ongoing decisions that related to it to ensure that staff were provided with clear, accurate and relevant guidance to help ensure people's care was responsive.

We recommended that the provider ensured that accessible information was considered for all people's needs.

People were happy and told us they liked living at the home. Staff were kind, caring and compassionate and people told us they were fond of the staff. People were treated with respect and their privacy and dignity was maintained. Independence was promoted, and people were encouraged and able to continue to retain their skills.

Staff ensured people were treated as individuals and had considered and acknowledged their life histories,

backgrounds and preferences. People told us there was enough to do to occupy their time and they enjoyed the support provided by staff and external entertainers. People were able to make suggestions and raise concerns and complaints and these were welcomed and learned from to ensure changes were made. People told us they were confident that staff would contact external healthcare professionals if they were unwell.

Following the inspection, once concerns were made known to the manager and provider they took immediate action to improve the quality of care to ensure people's safety.

Rating at last inspection and update
The last rating for this home was Requires Improvement. (Published 19 February 2019). There was a breach of regulation in relation to the leadership and management of the home. At this inspection, not enough improvement had been made and the provider was still in breach of regulation. The home remains rated Requires Improvement and has now been rated Requires Improvement at the last three consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified a continued breach in relation to the leadership and management of the home. We found two new breaches in relation to people's safety and staffing. Please see the action we have told the provider to take at the end of this report.

Follow-up
We will continue to monitor the intelligence we receive about this home. We will request an action plan from the provider to understand what they will do to improve the standards of safety and governance. We plan to inspect in line with our re-inspection programme. If we receive any concerning information we may inspect sooner.

You can read the report from our last inspection, by selecting the 'all reports' link for Oakleigh Residential Home on our website at www.cqc.org.uk.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below	**Requires Improvement**

Oakleigh Lodge Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was undertaken by two Inspectors.

Service and service type
Oakleigh Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home did not have a manager who was registered with the Care Quality Commission. This means that the provider is legally responsible for how the home is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the home since the last inspection. We had not asked the provider to submit a provider information return (PIR) since the last inspection. A PIR is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. A discussion took place with the manager to enable them to share this information with us. We took this into account when making our judgements in this report. We contacted the local authority for their feedback about the home.

During the inspection
We observed the care and support people received. 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 four people and two relatives about their experience of the care provided. We spoke with four members of staff, the manager and the provider. We reviewed a range of records about people's care and how the service was managed. These included the individual care and medicine administration records for five people. We looked at 10 staff files in relation to recruitment, training and staff supervision. A variety of records relating to the management of the home, which included policies and procedures, were also reviewed.

After the inspection
We sought assurances from the provider in relation to emergency evacuation plans, people's safety and care needs and staff training.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. The provider had not ensured there was sufficient oversight of medicines management or accidents and incidents to assure themselves that people were receiving safe care.

At this inspection, we continued to have concerns. The provider had failed to robustly address and mitigate risks in relation to the health, safety and welfare of people. This key question has deteriorated to Inadequate. This meant people were not safe and were at risk from avoidable harm.

Using medicines safely

● Medicines management was not always safe. Some staff had not been supported to gain the necessary skills to ensure they delivered safe care before they supported people. Some staff responsible for administering medicines had not had medicines training nor had their competence assessed before they were required to administer people's medicines. This included staff who worked alone overnight.

● One person had been prescribed medicines that are used to treat and minimise the risk of Deep Vein Thrombosis (DVT) or pulmonary embolism. (Pulmonary embolism is a blockage of an artery in the lungs). The person had only been administered half of their prescribed dose of medicines for a period of seven days. This had not been identified by the manager or staff and when this was raised with them they could not provide an explanation as to why the person's medicines had not been administered according to prescribing guidance. Following the inspection, CQC raised a safeguarding referral to the local authority for them to consider as part of their safeguarding responsibilities.

● One person was prescribed an inhaler to help manage the symptoms of Chronic Obstructive Pulmonary Disease (COPD is a lung disease which affects people's ability to breathe). The person's health condition had recently deteriorated, and they had been advised by an external healthcare professional to ensure they received their medicines four times a day. Our observations showed the inhaler the member of staff had given the person was empty and this had not been recognised. When this was raised with them, they lacked understanding in relation to ensuring the inhaler had sufficient medicines to be effective. They changed the inhaler and returned to the person. The person had been prescribed a spacer to use when having their inhaler administered. This is designed to assist the medicine to reach the person's lungs more effectively. The person was supported to have their inhaler administered without the use of the spacer and our observations showed the person did not have their medicines administered effectively.

● Staff had not ensured they followed best practice guidance when entering information onto people's medicine administration records (MARs). Most medicines had been entered onto MARs electronically by a pharmacist. When people required medicines that were not provided in pre-packaged blister packs, staff had sometimes entered the information about the person's medicines manually. Best practice guidance advises that two members of staff undertake this to minimise the risk of errors, this had not been implemented in practice and the MAR had only been completed by one member of staff. This increased the risk of errors occurring and was not in accordance with best practice guidance.

● Some people had been prescribed medicines that required closer monitoring and protocols when being

administered, due to the increased risk the medicines could be misused. The provider had not ensured staff were following best practice guidance which states two members of staff, who are trained in medicines administration, should dispense, administer and document when these types of medicines are administered. One person was prescribed this type of medicine at a time of day when there was only one member of staff working. When the provider was asked how they ensured they complied with best practice guidance they were unable to provide assurances and told us they were unaware of the guidance. They explained the member of staff would dispense the medicines and administer them to the person and when more staff came on duty the following day, they would count the remaining medicines and counter-sign the member of staff's actions. This was not safe practice and was not in accordance with best practice guidance and increased the risks that the medicines could be misused.

● One person was prescribed pain management medicines on an 'as and when required' basis. The provider had not ensured staff were provided with guidance which advised them of when to offer the person their medicines. On one night, a member of staff who had not received medicines management training or had their competence assessed when administering medicines, had documented that the person had experienced a fall. Records showed the member of staff had contacted the manager who had come into the home and administered the person's pain medicines. This did not promote safe care and increased the risk that the person's pain was not well-managed whilst they waited for the manager to attend the home.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Not all risks had been identified, assessed or managed effectively to ensure people's safety. One person was receiving treatment from community nurses. External healthcare guidance had advised staff to encourage the person to elevate their legs, rest on their bed each day for a minimum of two hours to relieve pressure and to be supported to walk regularly. Records showed, and staff confirmed the person's wounds were not healing and there were occasions when staff had documented the person's wounds had severely deteriorated. Risks in relation to the person's skin integrity had not been identified or assessed by the provider and staff were not provided with guidance to ensure they supported the person effectively and in a way that reduced further risk. Staff told us the person refused the support advised by the external healthcare professionals but were unable to evidence they had always offered support, and this had been refused. It was not evident that staff had encouraged the person to change position frequently to minimise the risk of pressure damage or to use their pressure relieving cushion when they were in the same position for an extended period. When staff supported the person to move they displayed signs of pain, their face grimaced and they told staff it hurt. Insufficient action had been taken to identify, assess and minimise risk to ensure the person was supported effectively or to ensure healthcare guidance was followed. This increased the risk that the person's skin integrity would deteriorate further.

● People who were at risk of falls were not always effectively assessed and measures were not always taken to ensure known risks were reduced. One person had experienced a fall before they moved into the home. The person's history of falls had not been identified by staff when assessing the person's needs and risks to the person were not identified and assessed. Staff were not provided with guidance about how to support the person in accordance with their needs or in a way that reduced known risks. The person had impaired vision and the impact this might have on their risk of falls had not been considered. The person had experienced two falls within a 10-day period, one of which had resulted in a fracture. The manager had demonstrated good practice by making a referral to the fall's prevention service, so they could offer advice and guidance to help reduce risks. However, whilst waiting for a response from them, the provider had not ensured they assessed risk in relation to falls to determine if the person's needs had changed or to ensure risks were identified, assessed and managed to reduce further risk of harm. One the day of inspection, the person experienced a further fall and was taken to hospital to check for injuries. The provider was not doing all they could to ensure risks were identified, assessed and managed to ensure the person's safety.

● Risks to people's safety in the event of a fire had not always been considered. There was one member of staff who worked overnight to provide care for up to 14 people. Records showed, and the manager and

provider confirmed, four staff who were lone workers had not undertaken fire training. One person told us it worried them when there was only one member of staff working overnight and explained that one night there had been a water leak at the home. The member of staff did not know what to do and had asked the person how they gained access to one of the rooms to try and resolve the problem. The person told us, "What if it had been a fire." Another person expressed their concerns about staffing at night and told us, "I wonder how they would cope with a problem."

● Personal emergency evacuation plans (PEEPS) were in place for most people. The provider had not identified that one person, that would require assistance from staff to safely evacuate the home in the event of an emergency, had not been assessed or their ability to evacuate the building considered, and staff had not been provided with guidance about how to support the person. PEEPS for one other person whose health condition and mobility had deteriorated, had not been reviewed to ensure it provided accurate guidance about how the person should be supported by staff. One person told us, "I am worried about fire safety, this hasn't been addressed. I just want some reassurance." These practices placed people at significant risk of harm. Following the inspection, we raised our concerns with East Sussex Fire and Rescue service for them to consider as part of their duties.

● People were not always supported with manual movement in a safe way. Staff had not always received training or had their competence assessed before supporting people with manual movement. Observations of the care provided raised concerns about staff's skills and competence. There was a lack of guidance advising staff of how to support people safely and effectively. One person was receiving treatment to their legs from community nurses. We observed on two occasions the person was supported by staff to use a wheelchair to mobilise from one area of the home to another. They were not supported to rest their legs on the wheelchair's footplates and their feet were observed to be touching the ground. This increased the risk of injury to the person's feet and ankles and placed them at increased risk of harm.

● The same person was assisted to stand from their chair by a member of staff. The member of staff placed their arm underneath the person's armpit and assisted the person to stand. We observed another person was supported in the same way by another member of staff. This is what is referred to as a 'drag lift' and increases the risk of injuries to people's arms and shoulders.

The provider had not ensured they provided care and treatment in a safe way for people. This placed people at increased risk of harm and was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Immediate assurances of people's safety and the skills of staff were sought from the provider. At the end of inspection, the manager ensured an emergency evacuation plan was in place for all people to ensure staff were provided with appropriate guidance. They ensured the member of staff responsible for working overnight had received an induction, so they knew what to do in the event of an emergency and had their competence assessed to ensure they were competent to administer medicines. After the inspection, the manager provided assurances they would ensure staff were booked to attend training on safe medicines administration, manual movement and fire safety. The provider sent us information to show staff had taken part in a fire drill.

● People were involved in discussions about their health and staff liaised with people and their GP to ensure any medicines prescribed were appropriate and met their current needs.

● Equipment was regularly checked to ensure it was safe to use.

Staffing and recruitment

● Staffing levels were not always sufficient to meet people's assessed levels of need. The provider had not ensured there was sufficient staffing overnight. People told us the staffing levels at night were a concern to

them and they worried about their safety if there was an emergency. There was one member of staff who worked overnight to provide care for up to 14 people. The provider had not considered staff numbers and people's assessed needs when deploying staff. It had been identified that one person required assistance from two members of staff to reposition as they were cared for in bed. When the manager was asked what would happen if the person required assistance overnight, they were unable to provide assurances and explained staff would support the person before they left in the evening and would offer support when they arrived again in the morning. This demonstrated staffing levels overnight were not aligned to the person's assessed level of need and this increased the risk that the person would not be supported appropriately should they require assistance.

● In January 2020, accident records showed one other person had slipped from their bed on two occasions and on one of these occasions had needed to be supported by two members of staff. This further demonstrated that the provider had not considered people's needs or risks to their care when allocating staff.

● Staffing numbers at night had not taken into consideration people's assessed needs and their prescribed medicines. One person was prescribed a medicine that was required to be dispensed, administered and documented by two trained members of staff. Staffing levels at night, when prescribing guidance had advised the person's medicines should be administered, meant there was only one member of staff to dispense and administer the person's medicines and this did not ensure staff were working in accordance with best practice guidance. When this was raised with the provider and they were asked what they would do to ensure the person's medicines were given according to best practice guidance, they explained that now this had been raised with them, they would ensure a member of day staff stayed on to ensure that two members of staff were available to support the person to have their medicines. There was a potential risk that if people were prescribed other medicines to take overnight, as and when they required them, that also required two members of staff to dispense them, that staffing levels would still not be sufficient to ensure these were administered safely.

● Records showed, and staff confirmed most people required the assistance of staff to safely evacuate the home in the event of an emergency. The provider had not considered how one member of staff would safely and effectively be able to evacuate people to safe areas of the home or evacuate the home in the event of an emergency. When this was raised with the provider and the manager they told us they both lived near to the home and could come and help in the event of an emergency. This was not sufficient and placed people and staff at increased risk of harm.

The provider had not ensured there was sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's assessed levels of need. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment processes helped to ensure staff were safe to support people. The provider had assured themselves that staff were of good character and suitable for the role before they started work.

● Staff's levels of experience were considered when allocating and deploying staff. New staff were required to work alongside existing staff to ensure they had time to understand people's needs and requirements.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People were not always protected from the risk of harm. Due to the concerns found at the inspection, we made three safeguarding referrals to the local authority in relation to people's safety for them to consider as part of their safeguarding duties.

● Staff had not always been supported to ensure they held appropriate skills and knowledge to protect people from the risk of harm. Staff who worked alone at night and were therefore responsible for people's safety and well-being, had not undertaken safeguarding adults at risk training and therefore the provider

had not assured themselves that staff would know what to do if they had concerns about people's well-being and safety.
● People told us they felt safe and comfortable with staff and they knew who to speak to if they were ever worried about their care.

Preventing and controlling infection
● People were protected from the spread of infection. Staff used protective equipment and disposed of waste appropriately. The environment was clean, and people told us they were happy with the cleanliness of the home. A notice was displayed on the door to the home advising people to avoid visiting if they had been exposed to viruses.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection, this key question was rated as Requires Improvement. There were concerns about the oversight of staff's training and skills and staff had not always been supported to undertake training to ensure people's safety or needs were effectively met.

At this inspection, we continued to have concerns. There was a continued lack of oversight and consideration of the skills and abilities staff required to meet people's needs safely and effectively. This key question remains Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● People were not always supported by staff that held appropriate skills, experience or abilities to meet their assessed needs. Staff had not undertaken training in relation to safeguarding people from abuse and improper treatment, medicines management, fire safety and safe manual movement. This had an impact on people's care and some people had not been supported in a safe way. The provider had not assured themselves that staff were competent to support people before delegating tasks and responsibilities to staff who sometimes worked alone. New staff had not always been supported to have an induction to ensure they were aware of what to do if there was an emergency or if they had a safeguarding concern.

● One person was receiving treatment from community nursing teams. The provider required staff to apply dressings to the person's wounds if the dressings applied by the nursing team were to come off in-between their visits. It was not evident what training or guidance staff had been given before they undertook this, and documentation showed there were times when the person's wounds had deteriorated severely. There was minimal guidance available to staff to inform them of how to support the person in a safe and consistent way. The provider had not ensured staff were provided with the relevant guidance or skills to ensure the person was supported safely and this placed the person at increased risk of harm.

● Most shifts were covered by a small staff team. There were times, however, when agency staff were required to work overnight. The manager had obtained some information from the agency staff's organisation to provide some assurances about their skills but had failed to identify that one agency staff who had worked at the home on a number of occasions, had not undertaken training in the safe administration of medicines or had their competence assessed. This was of concern as the member of staff was the only member of staff working overnight and they were responsible for the administration of medicines for 14 people.

The provider had not ensured there were suitably qualified, competent, skilled and experienced staff deployed. This contributed to a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt well-supported by the manager and they could approach them if they had any

concerns or needed assistance. Supervision meetings had been provided to enable staff to be provided with feedback about their practice and help identify any areas in need of further development.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet;

● People's needs were not assessed in accordance with best practice guidance. The provider did not use nationally recognised assessment tools to identify and assess people's needs and instead had their own systems. They had failed to ensure these systems were implemented in practice and it had not been identified that people's needs had not been assessed or that appropriate guidance had not been provided to staff. Staff had not always been provided with accurate and up-to-date information about people's needs and this increased the risk that people's needs would not be well-managed, and they would be provided with inconsistent care. This included guidance in relation to catheter care and how to support people with their mental-health needs.

● There was insufficient oversight to ensure risks were managed effectively, and people were receiving appropriate care. External heath care guidance had not been followed for one person who required support to minimise the risk of malnutrition. Staff were also not accurately monitoring the person to ensure they maintained a weight recommended by the GP and therefore had not recognised when the person had fallen slightly below this. The provider was not doing all they could to ensure the person's risk of malnutrition was minimised.

● Hospital records for two people showed that when they had been admitted to hospital for certain health conditions, they were found to be dehydrated. People's risk of dehydration had not been assessed by the provider and staff were not provided with guidance about people's needs which included how much the person should be supported to consume to maintain their health and minimise the risk of dehydration. We observed staff offering people drinks and providing assistance when needed.

● There was a small staff team who told us they knew people's needs well. Observations of staff's practice raised concerns about their knowledge of people's needs and how they should be supported in a safe, effective and appropriate way. Records showed, and people and staff told us there had been new staff employed and some shifts had occasionally been covered by agency staff. The lack of guidance was of relevance due to the use of agency staff and new staff who did not yet know people's needs.

People were not always provided with safe care and treatment to meet their needs. This contributed to a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's personal and oral hygiene needs had not always been assessed and staff had not been provided with guidance which informed them of the type of support people required. However, people were complimentary about staff and told us they were supported appropriately and in accordance with their needs.

● People were provided with equipment to enable them to be treated equally with others. For example, when people had physical disabilities they had access to walking aids to support them to move and position.

● People and relatives told us they felt well-cared for and they had confidence that staff would seek support from GPs or other external healthcare professionals if they became unwell.

● Technology was used so that people were able to call for staff's assistance by using call bells. The provider told us a sensor mat had been ordered for one person but was not yet implemented in practice. This would enable staff to be alerted and go to the person's aid when they attempted to mobilise.

● People were complimentary about the food and told us they were provided with choice. We observed people enjoyed their food. One person asked for second helpings, staff accommodated the person's wishes and they were provided with another plate of food which they told us they enjoyed. One person told us, "The food is fabulous, I've got an allergy and the chef is excellent."
● People could choose to eat their meals in the dining area or within their own rooms and their right to choose was respected. People enjoyed conversations with each other at the dining table and there was a sociable and relaxing atmosphere for people to enjoy their meals with others.

Ensuring consent to care and treatment in line with law and guidance
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 make 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff had not always received training on MCA and DoLS and did not always demonstrate that they understood how to support people when they had a health condition that had the ability to affect their decision-making abilities. Staff told us that one person often refused support for certain aspects of their care. They explained that the person had the capacity to make this decision yet records showed that at times they had documented that the person had displayed signs of confusion. Staff had not considered assessing the person's capacity to make decisions about certain aspects of their care to ensure the person fully understood the implications of their decisions and to ensure any support was provided in the person's best interests.
● Staff told us that some people displayed signs of short-term memory loss. The provider had not considered the impact this might have on people's ability to consent to staying at the home and receiving constant support and supervision. They had not assessed people's capacity to consent to staying at the home.

We recommend the provider seeks further information and advice about MCA and its associated codes of practice to ensure that staff have a better understanding of supporting people to make informed decisions about their care when they have a health condition that has the potential to affect their decision-making abilities.

Following the inspection, the manager arranged for staff to receive training on MCA and DoLS to ensure they fully understood their responsibilities.

● Three people were living with dementia. DoLS applications had been made to the local authority to ensure people were not deprived of their liberty unlawfully.
● Staff respected people's right to make decisions and supported them in the least restrictive way and in their best interests.

Adapting service, design, decoration to meet people's needs

● When people had mobility needs, they were provided with adequate space to move around the home. People were observed mobilising independently with their mobility aids.

● People had private rooms if they wished to spend time alone or receive visitors in privacy. Some people had been encouraged to personalise their rooms with items that were important to them. This helped to create a homely environment for them to spend their time in. People told us they felt comfortable living at the home as it felt homely and welcoming and our observations confirmed this.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection, this key question was rated as Good. At this inspection, this key question has deteriorated to Requires Improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

● Our observations found there was a lack of understanding of potential neglect by omission of care. A number of safeguarding issues we identified during our visit had not been recognised or reported by staff. Although staff told us they were aware of their responsibilities to keep people safe, they had sometimes failed to identify some of the practices had breached people's rights to receive safe and dignified care. This meant staff had not noticed or challenged failings in how people were sometimes treated.

● Due to the deployment of staff, staff did not always have enough time to enable them to understand people's care and support needs and associated risks. The provider had not ensured staff consistently treated people as individuals in being able to quickly respond to people's changing needs. We have reported this in more depth in the Safe and Effective key questions.

● People and their relatives praised staff's caring and compassionate nature. They told us people were treated with kindness and respect and overall our observations confirmed this. One person told staff they felt cold and staff immediately retrieved the person's cardigan and assisted them to put it on, enquiring if the person felt better. One person told us, "Staff are very caring, they sat with me the other day and reassured me when I was in pain." Another person told us, "I've got everything I need, I'm very happy living here." A relative told us, "I can't sing their praises enough."

● Staff told us they tried their best to ensure people could stay at the home if their needs changed or if they were reaching the end of their lives. They acknowledged the importance of people returning home if they had a hospital stay that had resulted in a deterioration in their needs. We observed efforts had been made to ensure one person who had recently returned from hospital was provided with adapted support and specialised equipment to enable them to continue living at the home. A member of staff told us, "There is an ethos here, people don't get moved on and we don't give up on people."

● People were treated in a respectful way and their privacy and dignity was maintained. When people required assistance with their personal care needs, staff provided this in a discreet and tactful way. A relative told us, "They treat everyone individually. They are not patronising, and people are treated with dignity. They don't force people to do things for their [staff] convenience."

● Staff respected people's right to privacy and information that was held about people was securely stored in cabinets.

● People were encouraged and able to retain their skills and independence. People told us they liked being able to do things for themselves yet were comforted knowing staff were there should they require assistance. Some people spent the day in their own homes and came back to the home to stay overnight so they had the peace of mind someone was there if they needed support. Others enjoyed trips out into the

local community with family or friends.

● People were supported to have relationships with their family and friends. We observed people receiving visitors who told us they felt welcome to visit at any time. People had been able to invite their relatives to enjoy a meal with them at Christmas time.

● People were observed enjoying conversations with staff as well as interacting with each other. There was a warm, friendly and relaxed atmosphere and people were seen smiling, laughing and responding positively to their interactions with staff.

● People's religious and cultural needs were established when they first moved into the home and people could choose if they wished to practise their faith.

Supporting people to express their views and be involved in making decisions about their care

● The provider had not always ensured staff had the information and support needed to provide care and support in a compassionate and person-centred way. This included designing appropriate routines, rotas and training arrangements. We have reported this in more depth in the Effective, Responsive and Well-led key questions.

● People told us they were involved in day-to-day decisions that affected their care and we observed staff demonstrating this in practice. People were asked how they wanted to spend their time, what they wanted to eat or drink and what clothes they wanted to wear. There was a relaxed atmosphere and people told us they would feel comfortable discussing their care needs with staff.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection, this key question was rated as Good. At this inspection, this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

- People's physical and mental health needs had not always been identified or considered. Staff had not always been provided with current guidance about people's needs when they had experienced changes in their condition. Reviews of people's care had not always been completed and when they had, it had not been recognised that staff had not been provided with clear, accurate and consistent guidance so they could support people according to their needs and external healthcare guidance.
- It was not evident how people had been involved in planning their care or ongoing decisions related to it. The manager had already recognised this and had plans to improve people's involvement to ensure they were actively involved in planning and reviewing their own care. A recent residents' meeting showed this had been discussed with people to gain their opinions and views about being more involved.
- People had not always been supported to plan for care at the end of their lives. The manager had recognised this and told us that when having discussions with people as part of the new care planning system, people's end of life care wishes would be discussed and planned.

These concerns were made known to the manager and the provider at the inspection and they provided assurances they would act to ensure people's needs were assessed and reviewed so the guidance provided to staff was current. Further information about this as well as the action we have ask the provider to take can be found in the Safe, Effective and Well-led key questions.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Some people were living with visual and hearing impairments. One person told us that they had not attended a recent residents' meeting as notices had been displayed advising people of the meeting, yet the person was unable to see them, and they had not found out about the meeting until after it had taken place.

We recommend the provider ensures that all people are provided with information in a way they can understand and that meets their needs.

- Staff had considered that some people required assistance with their communication. People with

differing communication needs and abilities were provided with appropriate support and equipment, so they could continue to pursue their preferred pastimes. For example, some people were provided with talking books, so they could continue to enjoy books or newspapers. Another person had been provided with a chalkboard so staff could write messages to the person to promote understanding due the person's impaired hearing.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The manager was in the process of devising person-centred care plans to recognise people's life histories, interest and preferences. Those that had been completed showed that staff had been provided with clear information about people's social and emotional needs. Staff demonstrated a good understanding of people's preferences and dislikes and people told us they were happy with the way staff supported them.

● There was an emphasis on what was important to people. A member of staff, with people's involvement, had introduced signs for people's doors with summaries of what was important to them, what they enjoyed doing and things they liked. Staff told us these were useful for new staff or agency staff who did not yet know people's needs.

● There was a warm and friendly atmosphere. People told us they liked living at the home as they could choose how they spent their time. Some people chose to spend time in their rooms and told us that staff respected this but ensured they were not socially isolated as staff spent time with them.

● External activity professionals regularly visited the home to offer both music and exercise sessions. People told us how much they enjoyed this, and we observed some people enjoyed taking part in a fun, lively music session. Other activities such as arts and crafts were also offered to provide people with a more sensory and quieter pastime.

● A member of staff had recognised the importance of reminiscence and walls in the lounge and dining room were decorated with memorabilia, posters and items that people might recognise from their younger years.

● People had been involved in an initiative called, 'Postcards of kindness.' This asks people to write and send postcards to people living in care homes. Postcards people had received were displayed in the dining area and people and staff told us how much this had engaged people and encouraged them to reminisce. The manager told us it had encouraged people to discuss their life histories, jobs and experiences and people had enjoyed sending postcards to people in other care homes who shared the same interests and background as them. There were plans to network with other local homes so that people could communicate with people who lived in the local area.

● Some people continued to enjoy time outside of the home. The manager offered people trips to the seaside to provide a change of scenery.

● Residents' meeting minutes showed that people had been supported to enjoy Christmas and staff had offered to take people Christmas shopping or assistance with wrapping presents for their loved ones and friends.

● People told us there was enough to occupy their rime and one person told us the reason they liked living at the home was because, "It's so laid back here, I can do what I want." Another person told us that one member of staff, "Really goes the extra mile to make it special." A relative told us, "They're always introducing little things. They're doing a project around personalising Zimmer frames with handy bags on."

Improving care quality in response to complaints or concerns

● The provider had a complaints policy. When one person had raised a minor concern, this had been dealt with appropriately and in accordance with the provider's policy.

● People told us they felt comfortable raising issues of concern to the management team and most people told us they felt no need to complain as they were happy with the care they received.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. The provider had failed to ensure good governance and had not continually improved the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made and the provider was still in breach of regulation 17. There were concerns about the oversight of people's safety and care and this key question has remained Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Following the last inspection, when a breach of regulation was found, we asked the provider to send us an action plan to inform us of what they would do and by when to improve the service. The provider had failed to send us an action plan to provide assurances of how they were planning to improve the service.
- At this inspection, the provider had not maintained sufficient oversight to ensure the service and quality of care continually improved. The provider has been in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at the last three consecutive inspections. The home has also been rated as Requires Improvement at the last three consecutive inspections.
- Since the last inspection, a new manager had been recruited who had worked at the home for almost 12 months. They were in the process of applying to be the registered manager. The management team consisted of the manager and the provider, who regularly worked at the home. Since being in post, the manager had introduced some new systems such as audits to enable them to have improved oversight. Shortfalls in some people's care found as part of our inspection raised concerns about the effectiveness of the auditing systems and the oversight of people's care. It had not been recognised that people's needs had not been assessed, identified or met effectively and we had serious concerns about people's safety.
- The provider had conducted their own quality monitoring audit in 2019. This had looked at the management of the home and people's care but had failed to identify that people's needs had not been assessed nor appropriate guidance provided to staff. The provider had commented, 'Reviews up-to-date,' however, our observations showed that care plans had not been reviewed to ensure that they met people's current needs when these had changed due to a deterioration in their health or physical needs.
- Neither the manager or the provider had identified or considered the implications and increased risk posed when some staff were supporting people who had not undertaken training or had their competence assessed. They had not assured themselves that all staff held appropriate skills to support people safely. The oversight of staff's training was an area of practice in need of improvement at the last inspection and insufficient action has been taken by the provider to ensure this improved.

● Records, to ensure staff were provided with guidance, were not always well-maintained. People's needs had not been identified or assessed and the lack of guidance meant risks to people's care were not well-managed. This had not been identified by either the manager or the provider. The manager had started to write new care plans for some people that helped to identify their social and emotional needs and provide staff with details about the person's life history and their preferences. They had plans to introduce these for all people, but these were not yet fully implemented. There was no apparent system to ensure that when new care plans were being developed, that people who had more complex needs and required more assistance from staff, were prioritised.
● Staff told us that some people refused support, and this meant they were unable to ensure external healthcare professional's guidance was implemented. The provider had not ensured staff were provided with clear guidance within people's care plans to help inform their practice. Staff had not always documented that they had offered people support and it had been refused. This raised concerns about the care people had been provided with, as it was not evident if they had received the appropriate support of if staff had failed to document their actions.
● Concerns were raised with the provider about staff not following best practice guidance when administering medicines that required more rigorous monitoring. This helps to ensure risks are minimised in relation to the potential risk of medicines being misused. The provider was asked for their medicines policy. The policy did not provide guidance to staff, based on best practice guidance, to ensure they dispensed and administered these types of medicines in a safe way.
● The provider has conditions on their registration, which clearly state that they are not permitted to provide nursing care as the premises, management and staffing would not be suitable to meet the needs of people who required support with their nursing needs. We found that staff were providing wound care to one person. Staff had not undertaken training to inform them of how to do this safely and this increased the risk of harm to the person.

The provider had not ensured that they assessed, monitored or improved the quality and safety of the service sufficiently. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the manager acted to ensure that immediate risks to people's safety were mitigated. The manager and provider were receptive to our feedback and provided assurances that the concerns found as part of the inspection would be acted upon and people's care would be improved. The manager shared new care plans that had been devised for some people in response to our findings on the day and these provided assurances that systems were being implemented to improve the quality of care people received.

● The manager and provider were aware of their responsibilities and had notified us of incidents that had occurred at the home. This helped enable us to ensure appropriate actions had been taken in relation to people's care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong: Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider's aims were to provide a homely, relaxed environment for people. Staff ensured this was demonstrated in practice. People and their relatives told us they liked the home as they thought it was a "home-from-home" and had a relaxed and friendly atmosphere. Relatives told us they liked that the focus was on people's experiences and they appreciated the homely-feel provided. A relative told us, "It is a lovely, lived-in home. They look at the care side of things not the appearance and that is what my relative needs."

Another relative told us, "It feels like someone's home. It's a little chaotic but I like that, it's familiar." This was echoed by staff and one member of staff told us, "It is run as a family, not a business, it is run for the people."

● People, relatives and staff were complimentary about how the home was managed and provided positive feedback about the manager's actions since they had been in post. One person told us, "We are very lucky to have a manager who will roll her sleeves up and get stuck in."

● Residents' meetings, surveys and a suggestion box enabled people and their relatives to provide feedback on the care provided and in the running of the home. Records showed that people's feedback in relation to food choices and trips outside of the home had been listened to and acted upon. The manager had written on the notice board encouraging people to complete suggestion cards and welcomed feedback that was both positive as well as constructive.

● Staff told us they were able to raise ideas and suggestions at any time yet were also encouraged to do this within staff meetings. Staff were kept informed of issues that might affect the running of the home and people's care.

● People and relatives told us the manager and provider were open and honest and they were kept informed if there were changes in people's needs or if care had not gone according to plan.

● The manager and provider worked in partnership with external health professionals. Regular meetings with other care home managers within the city enabled the manager to share practice. The manager had been asked to present at one of the meetings and share the success of the 'Postcards of kindness' initiative and talk about the impact this had on people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment. The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users.

The enforcement action we took:

We served a Warning Notice for the breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to become compliant by 15 May 2020.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered person had not ensured that systems and processes were established and operated effectively to: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The enforcement action we took:

We served a Warning Notice for the breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to become compliant by 15 May 2020.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The registered person had not ensured that there were: Sufficient numbers of suitably qualified, competent, skilled and experienced people That staff had received appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

The enforcement action we took:

We served a Warning Notice for the breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to become compliant by 15 May 2020.