Habilis Operations Limited

Sutton Lodge Residential Care Home

Inspection report

Station Road
Sutton-on-Sea
Mablethorpe
Lincolnshire
LN12 2HR

Tel: 01507441905

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 22 December 2017. The inspection was unannounced. Sutton Lodge Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Sutton Lodge Residential Care Home is registered to provide accommodation and personal care for 24 adults of all ages. The service can also provide care for people who have physical adaptive needs. There were 14 people living in the service at the time of our inspection visit. Some of the people lived with dementia and had special communication needs.

The service was run by a company who was the registered provider. 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. In this report when we speak about both the company and the registered manager we refer to them as being, 'the registered persons'.

This is the fourth consecutive time the service has been rated as 'Requires Improvement'.

At the last inspection on 13 October 2016 although there were no breaches of regulations we found shortfalls in the arrangements that had been made to manage the service so that people consistently received safe and responsive care. At the present inspection we found two breaches of regulations. This was because the registered persons had failed to assess risks to people's health and safety and had not done all that is practical to keep people safe. In addition, the registered persons had failed to assess, monitor and improve the quality and safety of the service in the carrying on of the regulated activity. This was because people had not been fully involved in the development of the service and quality checks had had not always resulted in shortfalls quickly being quickly put right. In addition, the registered persons had not made robust arrangements to ensure that the service complied fully with a number of regulatory requirements. You can see what action we have told the registered persons to take at the end of the full version of this report.

Our other findings are as follows. We found that improvements were needed to ensure that people were fully safeguarded from the risk of financial mistreatment. In addition, lessons had not always been quickly learned when things had gone wrong. Furthermore, background checks on new care staff had not always been completed in the right way. However, medicines were managed correctly and sufficient care staff had been deployed.

Suitable arrangements had not always been made to enable people to receive care that fully promoted effective outcomes. This included national guidelines not always being followed to ensure that care was always provided in a lawful way and was the least restrictive possible. Furthermore, some parts of the

accommodation were not designed, adapted and decorated to meet people's needs and expectations. Although in practice care staff knew how to provide people with most of the practical assistance they needed, some of them had not received all of the training that the registered persons considered to be necessary. In addition, some of the arrangements used to ensure that people had enough hydration and nutrition to maintain a balanced diet were not robust. However, suitable provision had been made to help people receive a coordinated care when they moved between different services and people had been supported to receive on-going healthcare assistance.

Care staff had not always been given all of the resources they needed to provide people with a service that consistently promoted their dignity. However, people were supported to express their views and be actively involved in making decisions about their care. In addition, people's privacy and independence were respected and confidential information was kept private.

People did not always receive responsive care and treatment including having information presented to them in an accessible manner. In addition, people had not been offered sufficient opportunities to pursue their hobbies and interests and to engage in social activities. However, suitable provision had been made to promote equality and diversity. This included the registered persons recognising the importance of appropriately supporting people who chose gay, lesbian, bisexual and transgender lifestyles. Records showed that complaints and concerns had been properly managed and resolved. Furthermore, suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Records did not demonstrate that sufficient attention had been given to promoting the financial sustainability of the service. However, the registered manager promoted a positive culture in the service that was intended to achieve good outcomes for people. Care staff had been helped to understand their responsibilities to develop good team work and to speak out if they had any concerns. Furthermore, the registered persons were actively working in partnership with other agencies to support the development of joined-up care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not fully protected by the prevention and control of infection.

People had not always been provided with care that reduced avoidable risks to their health and safety and lessons had not always been learned when things had gone wrong.

Suitable arrangements had not been made to fully safeguard people from the risk of financial mistreatment.

Background checks had not always been completed in the right way before new care staff were appointed.

Medicines were managed safely.

Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Suitable arrangements had not always been made to ensure that care was always provided in a lawful way and was the least restrictive possible.

Some parts of the accommodation were not designed, adapted and decorated to meet people's needs and expectations.

People were not consistently helped to eat and drink enough to maintain a balanced diet.

Care staff had not received all of the training the registered persons considered to be necessary.

There were suitable arrangements to enable people to receive coordinated care when they used different services.

People had been supported to receive on-going healthcare

support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care staff had not been given all of the guidance and resources they needed to always provide people with care that promoted their dignity.

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

People's privacy and independence were respected and promoted.

Confidential information was kept private.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not always received personalised care that was responsive to their needs including their need to have information presented to them in an accessible way.

People had not been offered sufficient opportunities to pursue their hobbies and interests and to take part in a range of social activities.

Equality and diversity were not fully promoted.

People's concerns and complaints were listened and responded to in order to improve the quality of care.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Suitable arrangements had not been made to assess, monitor and improve the quality and safety of the service.

The registered persons had not taken all of the steps that were necessary to ensure that the service fully complied with regulatory requirements.

There was a registered manager who was promoting an open culture in the service.

Care staff had been helped to understand their responsibilities to develop good team work and to speak out if they had any concerns.

The service worked in partnership with other agencies to promote the delivery of joined-up care.

Sutton Lodge 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 registered persons continued to meet 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.

We used information the registered persons sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 22 December 2017 and the inspection was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is someone who has personal experience of using this type of service.

During the inspection we spoke with 10 people who lived in the service and with four relatives. We also spoke with a care worker, two senior care workers, the chef and the administrator. In addition, we spoke with the activities manager, the deputy manager and the registered manager. We observed care that was provided in communal areas and looked at the care records for four people who lived in the service. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

In addition, 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 speak with us.

After the inspection visit we spoke by telephone with a further three relatives.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living in the service. One of them said, "Yes, overall it's pretty well run I suppose. A bit tatty at the edges I suppose but I'm cared for well enough." A person who lived with dementia and who had special communication needs smiled and waved in the direction of a member of care staff when we used sign assisted language to ask them about their experience of living in the service. Relatives were confident that their family members were safe. One of them remarked, "The care here is good enough but they can be short staffed on some days."

However, we found that suitable arrangements had not been made to assess, manage and reduce risks to people's health and safety. We found that there was a security risk relating to access to the accommodation. We also noted that records were not available to show that the registered persons had fully implemented a number of improvements that had been recommended by the local fire and rescue authority. Furthermore, we found that some of the on-going fire safety checks that the registered persons said were necessary were significantly overdue or had not been completed at all. In addition, the registered manager told us that it was necessary to regulate the temperature of hot water so that there was less risk of people being scalded. However, one of the two taps we checked was operating at a temperature that would readily cause injury.

We also noted that suitable provision had not been made to securely store hazardous substances so that they could only be used by members of staff for their correct purpose. This included wood hardener that was marked as being 'highly flammable' and 'poisonous'.

We found that robust arrangements had not been made to support people who were at risk of developing sore skin. The shortfalls included care staff not being given sufficient guidance about the care that needed to be provided resulting in confusion about the assistance they were expected to deliver. Furthermore, records showed that this care had not always been provided in the way that the registered manager said was necessary to reduce the risk of people developing pressure ulcers.

Lessons had not always been learned when things had gone wrong so that people were suitably protected from the risk of avoidable accidents. We were told that new arrangements had been made for a person to be more frequently checked at night because they had fallen when attempting to get out of bed without assistance. However, there was no written information to guide care staff about the need to complete these additional checks and care staff were not aware of the arrangement. In addition, records showed that the additional checks were not routinely being completed.

We found that robust arrangements had not been made to assess, review and monitor the provision needed to promote good standards of hygiene. We were told that an infection control audit was regularly completed so that potential risks to the prevention and control of infection could quickly be addressed. However, records of the most recent audit could not be found and so we could not be assured that suitable checks had been undertaken. We found a number of shortfalls. One of these was the wash hand basin in the medicines store room that was dirty and encrusted with lime-scale. Furthermore, the side of the basin was rusted away and so could not be cleaned.

Another shortfall was the surround to a wash hand basin in one of the bedrooms. The laminate surface had worn away exposing the chipboard interior. The chipboard was damp, stained and could not be effectively cleaned. In addition, to these defects we found that a hot water tap fitted to the wash hand basin in one of the communal bathrooms did not work at all. This resulted in people not being able to wash their hands in comfort increasing the risk that they would not do so at all. These shortfalls had reduced the registered persons' ability to deliver harm-free care that helped people to avoid preventable infections.

We raised our concerns about the management of risks to people's health and safety with the registered manager. They assured us that each of the shortfalls in question would immediately be addressed in order to ensure that people received harm-free care that met their needs and expectations.

Failure to assess risks to people's health and safety and to do all that is practical to keep people safe was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although care staff knew how to safeguard people from situations in which they might experience abuse, the registered persons had not made suitable provision to fully safeguard people from the risk of financial mistreatment. This was because robust and transparent systems were not being followed to assist those people who wanted help to manage their personal spending money. We were told that some people had requested the service to hold small amounts of money for them. This was so that they had enough to pay for things such as consultations with the visiting hairdresser. We were told that detailed records were kept to show how these funds were spent and how much money was left. However, when we checked the records for two people we found that neither of them were accurate. This was because there were no receipts for some of the expenditure and furthermore the records did not match the cash balances that were left. These shortfalls in the administration of people's personal money reduced the registered persons' ability to robustly protect people from the risk of financial mistreatment.

We examined the procedure used by the registered persons when recruiting two new members of care staff. Records showed that there were shortfalls in the checks that had been completed. We noted that in each case the registered persons had not obtained a suitably detailed account of the applicants' employment histories. This shortfall had reduced the registered persons' ability to determine what background checks they needed to make. However and in practice, a number of assurances had been obtained including security clearances to show that the applicants did not have relevant criminal convictions. In addition, the registered manager assured us that no concerns had been raised about the performance of the two members of care staff in question since they had been appointed. They also told us that the arrangements used to appoint new members of staff would quickly be strengthened to address our concern.

There were reliable arrangements for ordering, storing, administering and disposing of medicines. There was a sufficient supply of medicines and they were stored securely when not in use. Care staff who administered medicines had received training. In addition, we saw them correctly following the registered persons' written guidance to make sure that people were given the right medicines at the right times. This included carefully checking to make sure that the correct medicines were being dispensed and accurately recording each occasion on which this was done.

Records showed that the registered persons had calculated how many care staff needed to be on duty. This had been done taking into account the number of people living in the service and the care each person needed to receive. Records showed that the service was being staffed in line with the minimum level set by the registered persons. We concluded that there were enough care staff on duty because we saw people receiving the practical assistance they needed.

Requires Improvement

Is the service effective?

Our findings

People were confident that the care staff knew what they were doing and had had their best interests at heart. One of them said, "I find most of the staff to be attentive and helpful." I don't have any concerns. Some are more interested than others in the job but none of them are bad." Most relatives were also complimentary about this matter with one them remarking, "I have no trouble with the staff who seem to know what they're doing and get on with it. Sometimes they're rushed but that's not their fault that's down to the owner."

However, we found that national guidelines had not been consistently used to promote positive outcomes for people by seeking consent to care and treatment in line with legislation. This was because some of the arrangements used to implement the safeguards contained in the Mental Capacity Act 2005 (MCA) were poorly organised and recorded. The Mental Capacity Act 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 law 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 in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The authorisation 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 Mental Capacity Act 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that suitable arrangements had not always been made to obtain consent to care and treatment in line with legislation and guidance. We were told that the registered persons considered it necessary for people or their representatives to give explicit and recorded consent to all parts of the care that was provided. We were also told that this consent needed to be updated at least once a year to make sure that any changes were fully agreed. We examined the records that had been completed in relation to three people. We noted that some of the records were out of date, some had not been completed in the right way and others were missing altogether. These shortfalls had reduced the registered persons' ability to ensure that they sought consent to care and treatment in the right way.

Furthermore, there were shortfalls in the arrangements the registered persons had made to ensure that care was always provided in a lawful way by obtaining deprivation of liberty authorisations when necessary. We were told that five of the people accommodated in the service lived with dementia. Although each was said to lack mental capacity to make decisions about their care we noted that a deprivation of liberty authorisation had only been sought for one of them. There were no records to assure us that a careful assessment had been completed to show that the people concerned would not benefit from the additional safeguards that follow when someone is subject to an authorisation.

We were also concerned to find that at the time of our inspection visit no records at all were available to show that an authorisation was in place for the person said to have been provided with these additional protections. In addition, when we asked two care staff about this matter they assumed that authorisations were in place for some of the five people concerned. They considered this to be necessary to validate the way in which their care was being provided. This was because the level of care and supervision involved necessarily resulted in each person's freedom being appreciably restricted. Although in practice the five people were receiving care in the least restrictive way possible, shortfalls in the arrangements used to obtain and use authorisations had reduced the registered persons' ability to ensure that people who lived in the service only received lawful care.

We found that some people's individual needs were not fully met by the design, adaptation and decoration of the accommodation. This was because suitable steps had not been taken to support people who lived with dementia to find their way around their home. Although signs were fitted to bathroom and toilet doors, little had been done to distinguish each person's bedroom door so that there was less risk of them entering the wrong room. The doors were not painted in different colours. Furthermore, photographs and other personal keepsakes had not been displayed to help people recognise their bedroom. In addition, we saw people mistakenly entering other people's bedrooms and care staff told us that this regularly occurred in the service.

Other shortfalls included bedroom furniture that was mismatched, chipped and damaged. We also noted that a clock in the main lounge only had an hour hand and this was pointing to the wrong time. In addition, we found that there was a large refrigerator in the dining room. Although this had been provided for use by people who lived in the service, in practice it was noisy and intrusive for people who sat at the nearby dining table.

We also noted that some parts of the grounds did not provide people with a pleasant setting in which to live. When we arrived at the service we found that immediately outside the front door there was a large tin that was overflowing with cigarette ends. This made the area look unsightly as did a large builder's sack that was blowing about in the wind. Other parts of the grounds also looked run down as the earth was covered with uneven plastic sheeting that was held in place with roof tiles. In various places weeds were growing through the sheeting.

Although the back garden was well maintained, the poor maintenance of the building detracted from the overall appearance of this space. The defects here included a number of wooden windows where the paint was discoloured and peeling. Indeed, one window sill even had a large hole in it due to extensive rot. Furthermore, we noted that the gutters and barge-boards around all of the building were dirty and discoloured with mould.

The registered manager told us that special arrangements had been made to support a number of people who were at risk of not eating and drinking enough to maintain a balanced diet. This included regularly offering people the opportunity to have their body weight regularly checked so that any significant changes could be brought to the attention of a healthcare professional. However, we noted that this assistance had not always been provided in the right way. This was because records showed that on some occasions people's weights had not been taken and on other occasions had not been correctly analysed.

We were also told that care staff were carefully monitoring how much nutrition and hydration some people were consuming each day. However, again records showed that these checks were not always been completed in the right way. This was because the actual amount of food consumed had not been recorded. Furthermore, no action had been taken when people had not had enough to drink when measured against

the minimum set by the registered manager in consultation with healthcare professionals. Although suitable arrangements had been made to modify some people's food and drinks so that they were easier to swallow, the shortfalls we found had increased the risk that people would not receive all of the assistance they needed to have a balanced diet.

In addition, when we were present during the lunch time meal we found that some aspects of the dining experience were not well organised. We noted that one person did not receive the meal they had previously requested. We saw that several other people did not eat most of their meal and we did not see care staff enquiring if they wanted something else. Another person who did say that they wanted something else was offered a pudding instead of their main meal and then they had to wait 15 minutes for it to be delivered. More generally, we noted that the service of the meals was disorganised with people who were seated at the same dining table often not starting their meal at the same time. These shortfalls reduced people's ability to enjoy their experience of dining together.

Records showed that care staff had received introductory training before they provided people with care. The registered manager said that for care staff who did not have a recognised qualification this training involved completing the Care Certificate. This is a nationally recognised training scheme that is designed to ensure that new care staff are competent to care for people in the right way. However, we found that suitable arrangements had not been made to put this commitment into action for a recently appointed member of care staff. We were also told that the registered persons considered it necessary for care staff to receive on-going refresher training to keep their knowledge and skills up to date. However, again records showed that some care staff had not received all of this training and furthermore there was no clear plan to address the shortfalls. Nevertheless, we found that in practice care staff knew how to provide people with most of the practical assistance they needed. Examples of this were care staff knowing how to assist people who needed help to promote their continence or who needed assistance due to reduced mobility.

We found that arrangements were in place which were designed to assess people's needs and choices. Records showed that the registered manager had established what assistance each person needed before they moved into the service. This had been done to make sure that the service had the necessary facilities and resources. Records also showed that the initial assessments had suitably considered any additional provision that might need to be made to ensure that people did not experience discrimination. An example of this was the registered manager carefully asking people if they had particular expectations deriving from cultural or ethnic identities about how their close personal care should be provided and who should deliver it.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. This included the registered manager preparing written information about a person's care needs to pass on to other providers such as healthcare professionals in hospital. Another example of this was care staff making arrangements for people to be accompanied at hospital appointments so that they could give additional information to healthcare professionals.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dietitians.

Requires Improvement

Is the service caring?

Our findings

Most people were positive about the care they received. One of them remarked, "The staff are fine with me and I get on well with them." Most relatives were also confident that their family members were treated with compassion and kindness. One of them remarked, "Yes, I've no concerns about the staff who are kind but they're very rushed on some days."

However, we found that care staff had not been fully supported to deliver the caring response they said that they wanted to provide. We were concerned to observe an occasion when care staff had not had time to empty a continence promotion aid that a person told us they had used several hours earlier. We asked the registered manager to arrange for the aid to be emptied. They explained that on some occasions in the past the person had declined to allow care staff to remove the aid. However, they then arranged for care staff to remove the aid to which the person agreed.

We also witnessed another occasion when a person did not receive a caring service. This occurred in the dining room when a member of care staff was rushed and abruptly told a person to remove their elbows from the dining table at which they were seated. We saw the person jump back due to being startled and we considered the tone of the communication to have been disrespectful.

However, we also witnessed other examples of people being treated with kindness and being given emotional support. An example of this occurred when we saw a member of care staff sitting with a person in their bedroom where they were both looking out of the window and counting the number of birds they could see in the garden. Another example was a member of care staff reassuring a person that they had not mislaid their favourite cardigan. They explained that it was being washed and would be returned to them as soon as possible.

Furthermore, people told us that care staff had been considerate and had made a special effort to welcome people when they first moved into the service. This had been done so that the experience was positive and not too daunting. The arrangements had included asking family members to bring in items of a person's own furniture so that they had something familiar in their bedroom when they first arrived.

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Most people had family and friends who could support them to express their preferences. Records showed and relatives confirmed that the registered manager and senior members of care staff had encouraged their involvement by liaising with them on a regular basis. In addition, the service had developed links with local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes.

People's privacy was respected and promoted. We noted that care staff recognised the importance of not intruding into people's private space. Bathroom and toilet doors could be locked when the rooms were in use. In addition, people had their own bedroom that they had been encouraged to make into their own

personal space. We also saw care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms.

People told us that they could speak with relatives and meet with health and social care professionals in private if they wanted to do so. In addition, we noted that care staff were assisting people to keep in touch with their relatives by post and telephone.

We saw that suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

Most people said that care staff provided them with all of the assistance they needed. One of them remarked, "The staff do help me a lot but they can be very pushed and you will have to wait at busy times. It's not down to them and they do what they can." Most relatives were also positive about the amount of help their family members received. One of them told us, "Overall, I think that people get the care they need."

However, we found that people had not always received personalised care that was responsive to their needs. This included their need to have information presented to them in an accessible manner. Records showed that care staff had prepared a care plan for each person. These were intended to describe the care each person needed and had agreed to receive. However, little had been done to present information in a user-friendly way for people who lived with dementia. People who have special communication needs often benefit from having information given to them through multi-media tools such as graphics and colours so that it is easier to understand. This oversight had reduced people's ability to be fully involved in the process of recording and reviewing the care they received.

In addition, we found the progress notes that were completed at the end of each shift to describe the care each person had received were disorganised and not well managed. This was because they were not always stored in date order and so were difficult to follow. These shortfalls limited the opportunity people had to have meaningful access to important documents and records that had been created in their name.

Nevertheless, other records confirmed that in practice people were receiving most of the care they needed as described in their individual care plan. This included help with managing a number of on-going medical conditions, washing and dressing and promoting their continence.

The registered manager told us that it was important to offer people a wide range of opportunities to pursue their hobbies and interests and to enjoy taking part in a range of social activities. We were told that this involved both inviting people to attend regular small-group activities and offering them one to one support. However, we noted that the activities manager was only present in the service for 10 hours each week and members of staff told us that this was not enough time for everyone to receive the individual support they needed.

During the course of our inspection visit we saw a number of people taking part in a Christmas buffet in the lounge. However, at other times we did not see most people being given one to one support to enjoy individual activities. In addition, we were concerned to see people sitting for long periods of time in a withdrawn state and without any interaction. Furthermore, we were told that it had not been possible to arrange for entertainers to call to the service as there were no funds to make the necessary payments. We also noted that there were no realistic plans to address these shortfalls in the foreseeable future.

We found that the registered persons had made a number of arrangements to promote equality and diversity in the service. These included the registered manager being aware of how to support people who

had English as their second language, such as accessing translator services. In addition, we noted that the registered persons recognised the importance of appropriately supporting people who choose gay, lesbian, bisexual and transgender lifestyles. This included being aware of how to help people to access social media sites that reflected and promoted their lifestyle choices.

We saw that suitable provision had been made to acknowledge personal milestones. An example of this was people being helped to celebrate their birthdays in a manner of their choice. This usually involved the chef baking them a special cake. Furthermore, we were told that people had been enabled to share in community events. An example of this was people being helped to put their name on the electoral roll and being supported to cast their vote if they wished to do so. Another example was people being helped to take part in raising funds for national charitable events such as the poppy appeal on Remembrance Sunday.

There were suitable arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. Records showed that when the registered persons had received a complaint the matter had been properly investigated so that it could be resolved as quickly as possible.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. We noted that the registered persons had made the necessary arrangements for the service to hold 'anticipatory medicines'. These are medicines that can be used at short notice under a doctor's guidance to manage pain so that a person can be helped to be comfortable. In addition, records showed that the registered manager had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home. We also noted examples of care staff kindly supporting relatives at this difficult time. This included making them welcome so that they could stay with their family member during their last hours in order to provide comfort and reassurance.

Requires Improvement

Is the service well-led?

Our findings

Most people considered the service to be well run. One of them said, "We have what we need here. The building is pretty basic but the staff are okay and things seem to run quite well day to day." Most relatives were also complimentary about the management of the service. One of them remarked, "I wouldn't say it's badly managed as people are treated with kindness and the care staff work hard and do their best."

However, we found that people who lived in the service had not been fully engaged and involved in making improvements. We were told that people had been invited to meet with the registered persons to share their experiences of living in the service but that no one had wanted to use this opportunity. Nevertheless, a number of people told us that they would welcome the chance to suggest ideas about the development of the service. However, we did note that relatives had been invited to give feedback about the service through completing a quality questionnaire. Records showed that in their responses relatives had been consistently positive about the care their family members received.

In their Provider Information Return the registered persons told us that it was important to operate robust quality checks to ensure that people reliably received safe care. However, we found that quality checks had not always been completed in the right way. This had reduced the registered persons' ability to quickly put right problems in the running of the service. These included the concerns we have described earlier in our report relating to the management of people's money, the provision of harm-free care and the way in which lessons were learned when things had gone wrong. Other shortfalls were in the recruitment of care staff, the promotion of people's dignity and the provision of social activities.

Although, there was a registered manager in post we noted that the registered persons had not made all of the provision necessary to meet regulatory requirements. The registered manager told us that the focus of the service had changed during 2017 to enable it to 'specialise' in caring for people who lived with dementia. They also told us that this new focus was reflected in revisions that had been made to the service's registration with us. In addition, they said that the registered persons had updated the service's Statement of Purpose accordingly. This is a legal document that the registered persons have to prepare to describe how they intend to provide people with safe, effective and responsive care. However, our records showed that an application had not been made to revise the service's registration. Furthermore, an updated version copy of the Statement of Purpose had not been submitted to us and a copy could not be found for us to see during the inspection visit. These oversights had reduced our ability to evaluate the service against information about its operation that the registered persons are required to give us.

We also noted that the registered persons had not told us about their receipt of the deprivation of liberty authorisation that we mentioned earlier in our report. It is a legal requirement that we be told about significant events such as this that occur in the service. This is because we need to promptly check to ensure that people are only receiving lawful care that keeps them safe in the least restrictive way possible.

In addition, we were not given the assurances we needed that there were robust systems to ensure the sustainability of the service. We were not shown any records either during or after our inspection visit to

show that the service's income was balanced against expenditure. This reduced the confidence we could have that sufficient income was being generated to support the continued operation of the service.

Failure to assess, monitor and improve the quality and safety of the services in the carrying on of the regulated activity (including the experiences of people receiving those services) was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that a number of systems were in place to help care staff to be clear about their responsibilities. This included there being a senior member of care staff who was in charge of each shift. In addition, arrangements had been made for the registered manager or the deputy manager to be on call during out of office hours to give advice and assistance to care staff should it be needed. Furthermore, care staff had been invited to attend regular staff meetings that were intended to develop their ability to work together as a team. This provision helped to ensure that nurses and care staff were suitably supported to care for people in the right way.

Care staff told us there was an explicit 'no tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the registered persons if they had any concerns about people not receiving safe care. They told us they were confident that any concerns they raised would be taken seriously so that action could quickly be taken to keep people safe.

We found that the service worked in partnership with other agencies. There were a number of examples to confirm that the registered persons recognised the importance of ensuring that people received 'joined-up' care. This included notifying local commissioners about vacancies so that arrangements could quickly be made for people to be admitted to the service from hospital after their treatment had been completed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to suitably assess risks to people's health and safety and had not done all that is practical to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to suitably 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 people in receiving those services).