Oban House Retirement Care Home

Oban House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over three days on 12 and 14 September 2017 and 26 October 2017, the first two days were unannounced and the third was announced. Due to unexpected circumstances on behalf of the Care Quality Commission (CQC) we were unable to complete the inspection after the first two days. Therefore a further site visit was announced in order to complete the inspection process.

Oban House Residential Care Home can provide accommodation and personal care for 30 older people. Some people living at the home were living with dementia and some needed support with mobility and sensory needs. There were 23 people living at the home at the time of our inspection.

The home was run by a company who were the registered provider. There was not a registered manager in post but the home had an acting manager who was not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the home. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run. The previous registered manager had been registered from October 2016 to August 2017. The current acting manager began with the home in July 2017 as a deputy manager and became the acting manager in August 2017.

In this report when we talk about the provider or the company we will refer to them as 'the provider'. Although the registered manager had left the home, they are discussed within the report and will therefore be referred to in this instance as the registered manager.

At the last inspection on the 10 January 2017, we found two breaches of the regulations. The home was rated as 'Requires Improvement' and we asked the provider to provide us with a report on the actions they planned to take in response to the breaches. The provider wrote to us to say what they would do to meet the legal requirements in relation to good governance and the provision of sufficient staffing to meet people's needs. We undertook a comprehensive inspection on 12, 14 September and 26 October 2017 in response to information of concern we had received about the home and to check whether the required actions had been taken to address the breaches previously identified. This report discusses our findings in relation to these breaches.

At this inspection we found improvements had been made in some areas, for example at the last inspection there was insufficient staffing, at this inspection there were now sufficient staff available with the skills to provide care that met people's needs so there was no longer a breach of this regulation. However further areas of improvement were identified, including a continued breach of the regulation relating to good governance and four further breaches of regulation in relation to safeguarding people from abuse, providing safe care and treatment, gaining suitable consent to care and notifying us of significant incidents that occurred while people were being supported.

At the last inspection the provider was in breach of regulation because their governance and quality

assurance checks had not been effective in resolving a number of problems in the running of the home. At this inspection that insufficient progress had been made in this area and this was a continuing breach. Quality assurance systems continued to not be suitably used to promote good governance, safety and the wellbeing of people. Personal and environmental risks including, falls risk, food hygiene and fire safety that could impact on people's wellbeing were not always suitably managed. Accident reporting was not sufficiently robust and at times the provider was reliant on other agencies to identify and ensure that the home was safe for its intended purpose.

Records and assessments were not consistently reviewed, kept or used to mitigate risks to people's wellbeing and safety. Staff and the acting manager acknowledged that peoples' care plans were not detailed enough and that they were not as personalised as they could be. There was a complaints system in place, but people and relatives were not fully aware of it, it was not consistently used and it did not demonstrate that the home learnt lessons from people's feedback.

The acting manager was building relationships with people, relatives, the staff team and community based health and social care professionals which is positive. However since the last inspection in January 2017 the home has deteriorated and there are now an additional breaches of Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider acknowledged that they had not had full oversight of the home as it continued to deteriorate. They had worked on the basis that the registered manager had quality assurance and management tasks in hand, and had been reassured that actions were being taken when they regularly met with the registered manager. The provider recognised that they would need to have more oversight of quality assurance systems in future and told us that they would be drawing up an action plan with the acting manager to address areas of poor practice discussed at the inspection.

People were not fully protected from the risk of abuse or potential abuse. Staff could tell us about different types of abuse and how they should report it; however, we found evidence that in at least two incidences peoples' wellbeing was not promoted as the registered manager did not effectively investigate or act on evidence that abuse may have occurred. They also failed to notify the CQC of these incidents and did not inform local safeguarding bodies in a timely way.

Practice around the safe administration of medicines had improved but was still not consistently safe. There were some improvements in how people's medicines were administered, however there was a lack of guidance in records of what medicines were for and when they should be taken. There was also a significant event investigation completed by a health professional when one person's wellbeing was impeded by their medicines not being administered as prescribed.

Peoples' nutritional needs were met, but they felt that they needed more choice in relation to different foods and wanted more home cooked food. Some dietary needs were not fully met, for example people with diabetes did not have guidance available in their care plans that supported catering or care staff to ensure they received a suitable diet.

People with and without capacity were not always supported in line with the principles of the Mental Capacity Act (MCA) 2005. People felt that they could make some day to day choices and some were also able to spend time independently in their local communities. However consideration of people's capacity had not consistently been given in areas such as having access to a front door key or living in a secured building.

Improvements in supporting people's privacy had been made. People felt listened to and that their dignity,

right to privacy and their diversity was respected by staff. Religious beliefs and access to a place of worship or being able to take part in a religious activity at home were made available. People and their relatives felt that they were involved in planning their care. Some people had more control over their daily experiences then others. Some people were more independent and could take part in meaningful activities in the community. Other people were reliant on relatives visiting and planned activities and many people told us that they missed not having as many activities at the home as there had been in the past.

Improvements in supporting staff had been made. Staff felt well supported and were very positive about the changes the acting manager had made since they began at the home in July 2017. They felt there was more structure in place and that the environment that people lived in was improving as it was cleaner. Staff had not received regular training and the acting manager was planning a schedule of courses to ensure this improved.

Improvements in staffing levels and recruitment processes had been made. People told us that there were enough staff to help them with their needs. This view was also shared by their relatives and other people visiting the service. People felt safe and that they were cared for by kind staff. People and relatives told us that staff were welcoming, and knew how to meet their care needs. Staff were recruited through suitable recruitment processes.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were sufficient staff to meet people's needs and safe recruitment processes were followed.

People had not always been protected from the risk of abuse as safeguarding concerns were not investigated or reported suitably.

People's medicines were not always managed and administered safely.

Risk assessments were not consistently reviewed to protect people from risk of avoidable harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People felt that the care given was good and that staff knew how to support their needs.

People were not consistently supported in the least restrictive way and the principles of the Mental Capacity Act (MCA) 2005 and were not fully considered.

Staff felt well supported by their new manager. However there were gaps in training and these aligned with areas where there had been a lack of understanding and practice concerns.

Peoples' nutritional needs were met and the environment of the building was improving.

Is the service caring?

Good

The service was caring.

People and relatives told us the staff were caring, kind and supportive.

We observed people being treated with sensitivity, humour and

respect and their personal rooms were individualised.

Staff demonstrated that they understood people's needs and preferences and people were happy and comfortable when spending time with staff.

People could access their communities and were supported to express their religious beliefs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people had a lot of control over what they did and had good access to their local community and interests. Others told us they would like more activities within the home.

Care records and plans did not give enough detail and guidance to staff to ensure people had personalised and consistent care.

Staff were sensitive to the needs of people living with dementia and gave people time to make the decisions about how they wanted to spend their time. Relatives were welcomed and involved in the home.

People and relatives felt able to approach staff and the acting manager if they had a concern. However, the complaints process was not consistently promoted or acted on.

Is the service well-led?

Requires Improvement

The service was not well led

There was an absence of management oversight in relation to identifying gaps in recording in relation to care records, audits and action plans. This resulted in the provider not recognising that aspects of the home were continuing to deteriorate.

The home did not have a registered manager in post. However an acting manager had made the decision to apply to become the registered manager.

Records, policies and documents were not consistently retained securely or complete.

The provider did not always notify the CQC of incidents that fell under the criteria for notifications of other events, for example safeguarding concerns.

Oban House 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by a notification of an incident that put a person using the home at risk. The information shared with CQC about the incident indicated potential concerns about the management of risk in relation to unsafe medicines management

The first two days of this inspection took place on 12 and 14 September 2017 and were unannounced. The inspection team consisted of two inspectors, a specialist pharmacist advisor and an expert by experience. The specialist pharmacist advisor had experience in providing pharmacy for people in a community setting. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We were unable to complete the inspection after the first two days due to unexpected circumstances on behalf of the CQC. Therefore a further site visit took place on 2 October 2017 in order to complete the inspection process and the provider was given 24 hours' notice. The inspection team consisted of two inspectors.

Before the inspection we checked the information that we held about the home and the provider. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. This included previous inspection ratings and statutory notifications sent to us by the registered manager that tell us about incidents and events that had occurred at the home. A notification is information about important events the home is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we observed care and activities in the communal spaces and people's rooms as well as outdoor spaces. We read five people's care records and nine medicine administration records. We also read other records which related to the management of the home such as staff files, training records, policies and procedures and quality auditing systems. We spoke with nine people, seven staff, three visitors and the acting manager and observed how people were supported during the day and with their meals. Subsequent to the inspection we contacted a further two relatives, two health professional, one commissioner and one local authority quality team so that we could further understand their experiences and those of people who could not talk with us. We have included their feedback in the main body of the report.

The last inspection of the home was 10 January 2017 where we found two breaches of the Health and Social Care Act 2008 (Regulated activities) 2014. The home was rated 'Requires Improvement'.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and were happy with the care given. One person told us "I feel safe, comfortable and warm". Relatives told us that they felt people were safe, looked after and that the building was secure. However, although people and relatives gave positive feedback about their safety we found areas of practice that required improvement.

At the January 2017 inspection people had not always been protected from the risk of avoidable accidents. This was because risks relating to falls and emergencies were not suitably managed. At this inspection we found further evidence that people were not being protected from the risk of potential harm. The provider had ensured, as detailed in their action plan from February 2017 that window restrictors were in place. They had reviewed personal emergency evacuation plans (PEEPs) to ensure people's individual ability to evacuate the building in the event of an emergency was considered and planned for. Staff told us they felt confident in the acting manager and that the home was running better and had a more structured approach to managing people's needs and risks. A health professional told us that the new manager had a positive influence and that the service was safer as they were assessing people more thoroughly before they were being placed at the home. However, falls risk assessments were not being reviewed regularly or when incidents occurred. Accident and incident records dated between July 2017 and October 2017 detailed that there had been regular recording of incidents relating to falls. These noted the cause and initial first aid and support given but did not consistently include details of what actions were taken in response to reduce the risk of a reoccurrence. On one occasion an incident had been considered significant enough for a paramedic to attend, but the record made did not detail what follow-on action had taken place to ensure the persons wellbeing. Care plans and risk assessments were not always updated following incidents and there was no system to collate information about themes such as falls so that further risks were mitigated. Significant events had occurred since the last inspection in January 2017 but the provider was not able to locate any accident and incident records between November 2011 and July 2017 to demonstrate how they investigated such events and took action to prevent people from the risk of potential harm.

The management of medicines had been an area that required improvement in the January 2017 inspection. This was due to medicines audits not taking place and poor practice around the administration of medicines not being identified.

At this inspection people's medicines were not always administered safely and the medicines systems had not been audited since November 2016. Some actions that the provider had set out in their action plan of February 2017 where not being implemented. We found, as we had in January 2017, that the main medicines cabinet and fridge temperatures were not being regularly checked. This meant that the medicines that were stored within, such as insulin and eye drops, were potentially being stored at a temperature that could damage their effectiveness as a treatment. People's medicines, administration records (MAR) sheets noted that daily medicines were being given and signed for. However, there was a lack of clear guidance available to staff in relation to 'as required' medicines. It was not clear if one person's medicines were 'as required' or daily medicines. There was a lack of detail to guide staff as to what some 'as required' medicines were for, the purpose of the treatment, the frequency of administration and the desired

effects. One person's records showed that they had received their pain relief medication too soon after the initial dose was given, and not after the four hours recommended by the pharmacy label. These examples demonstrated that the management of and safe administration of medicines was still an area that required improvement. The acting manager told us that they were aware of this and that a training programme was in place and that seven staff and the acting manager had completed medicines training. They also acknowledged that they would need to revisit their recording and auditing systems and would review the guidance given in relation to 'as required' medicines.

The providers continued failure to safely manage the administration of medicines, and to assess, record and mitigate risks to people's health and safety for example in relation to falls management. Demonstrated that the provider was not consistently providing people with safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At January 2017 inspection there were insufficient staffing levels to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were shortfalls in the arrangements used to deploy staff that resulted in people having to wait for care and not receiving prompt care that met their needs and expectations. An action plan was submitted by the provider in February 2017 that detailed how they would meet the legal requirement.

At this inspection the provider had followed their action plan and this breach had been addressed. Relatives and staff told us that there were enough skilled staff on duty to safely meet people's needs. In response to the staffing shortfalls the provider increased the numbers of staff available on shift and changed shift patterns to support key support times. During the inspection staff were present in areas where people were spending time and were able to take time to talk with people. Call bells were responded to quickly and people were supported at their own pace. Staff rotas over a six month period demonstrated that staffing levels were consistent. The acting manager and staff told us that eight staff had recently joined the team from a well performing home and this had been a very positive influence. A relative told us, "I think there is enough staff, they have lots of people to support, and there is a lot of work to do".

Staff we spoke with had access to safeguarding policies and procedures and were aware of how to report the types of abuse that older people and people living with dementia could experience. One staff member told us, "Any concerns I would raise to the manager, I would look for people that were unhappy or distressed and report it." Some staff described that they had recently had training in safeguarding awareness. However people were not fully protected from the potential risk of abuse as incidents were not always reported and responded to suitably.

Prior to the inspection we had received information relating to a significant medicines error at the home between March and May 2017 when medicines were reduced without authorisation from a medical professional due to an error with ordering repeat prescriptions. This was looked into by medical professionals as a significant event and agreed actions were made with the home to avoid similar occurrences in future. Actions were noted from the meeting that involved the then registered manager. However this incident was not shared with the CQC by the provider as they are legally obliged to do so. During the inspection we looked to see how the actions agreed had been used to ensure that lessons had been learnt. There was no incident record available detailing what had happened or that an investigation had taken place and no safeguarding had been raised with the local authority prior to the family raising their concerns with the CQC in August 2017. The acting manager was not aware of the incident that occurred prior to them starting in July 2017. The person involved in the original incident was no longer using the home and the medical professional confirmed there was no ongoing harm. However the person's relatives felt that their wellbeing had been impeded.

During the inspection a relative made us aware of a recent incident where their loved one had left the building without staff knowing. The relatives and police were involved in locating the person safely as there were concerns that due to their dementia they would not know how to return to the home and did not have warm clothing on. In response to the incident additional security of a locked back gate was added. However, the provider was not able to provide an incident form to confirm that an investigation had taken place and had not contacted the local authority in accordance with local safeguarding guidance.

Both of these incidents demonstrated that the provider did not ensure people were protected from abuse or improper treatment by failing to respond to allegations and record, report and investigate safeguarding incidents. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment processes were followed to ensure that new staff were safe to work with people. Staff files included previous work history, detailed application forms, proof of identity, interview records and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to ensure staff were suitable to work with people or children. The DBS is a national agency that keeps records of criminal convictions.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that the care given was good and that their support needs and preferences were known by staff. Relatives felt confident that staff knew how to meet the needs of their loved ones, some of whom had dementia and additional mobility support needs. One relative told us, "The staff are really welcoming; they know what they are doing and check out about my relative's needs all the time". However although people and relatives gave positive feedback, we identified areas of practice that required improvement.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Care Act (MCA) 2005. CQC is required by law to monitor the operation of DoLS. DoLS is the process to follow if a person has to be deprived of their liberty in order for them to receive the care and treatment they need.

One person told us that they had chosen the home for themselves as it was close to their local community. They were positive about the care and support given to them and were happy and comfortable in their home. However as an active independent person with capacity they told us they, "Had a problem with not having my own key", as this meant that they were taking carers away from other duties to answer the door to the home. This demonstrated that the provider did not always consider the least restrictive option for people within its care and was not always working within the principles of the Mental Capacity Act (MCA) 2005.

There were MCA and Deprivation of Liberty Standards (DoLS) policies in place. People told us that staff asked for consent before entering their rooms, and we observed staff asking for consent when giving medicines and offering activities. Staff told us that they understood that offering choice and receiving consent was required when supporting people with dementia. A relative told us that staff would respect their relative's choice to refuse their medicines, and would revisit them to offer the medicines again when this happened. However when we looked in people's care records, although people had signed consent forms for their care, and some family members were noted as legally being able to make decisions in relation to peoples' finances, there was no evidence or guidance on how consent should be gained, no mental capacity assessments relating to specific decisions and no record of best interests decision making processes.

We spoke with relatives and the acting manager and they told us that some people may not have capacity to make day to day and longer term decisions about their care and support needs. The front door was locked and the rear gate was also locked. People required support from staff to leave or enter the building which meant they were not free to come and go and were potentially being deprived of their liberty without the legal safeguards and authorisation for this to happen. For example, when one person living with dementia

left the building unescorted, staff were concerned for their wellbeing and contacted the person's family who in turn contacted the police. The person left of their own accord, but as they were living with dementia and required 24 hour care and support the staff felt that they should ensure the person was located safely. There was no assessment of capacity, best interest's decision or DoLS authorisation in place to say that the person was unsafe to leave the building and that staff had authority to respond in the way they did. This demonstrated that the provider did not always work within the principles of the MCA by assessing capacity and ensuring the legal safeguards such as DoLS were in place when required.

The acting manager acknowledged that although they were in the process of applying for the authorisation of a DoLS for one person who had fluctuating capacity, they did not have any mental capacity assessments or further applications or authorisations for DoLS in place. The acting manager confirmed that they would review people being able to have their own key and would give further consideration to making applications for DoLS authorisations for people who did not have capacity. This meant that people's liberty may have been deprived without lawful safeguards. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in January 2017 people's nutrition and weight was not consistently monitored. The registered manager took immediate action to address this at the time. At this inspection peoples' nutritional needs were consistently met, menus available were balanced and nutritious, and people maintained their weight well and told us they had enough food and drink available. One person told us, "The meals are always very nice with breakfast, lunch and tea and biscuits and an evening meal". People told us that staff knew their likes and dislikes in relation to food and drink and alternatives were provided when requested. Staff understood and we saw evidence that food and drinks were made available to everyone and that this was recorded and monitored throughout the day. We observed three meal times, and people were able to eat in either dining room, one providing a quieter eating space and another larger, more formal eating arrangement. Both areas provided a calm and positive experience. Tables were comfortably arranged with access to cutlery, drinks and condiments. People could also choose to eat in their rooms if they preferred.

We received variable feedback about how food was sourced and prepared, with some people stating that they liked the food but would prefer more home cooked food. One person told us, "The food is alright but there is a bit too much pre – made food from the supermarket". Another told us that they would prefer more fresh fruit being made available. People told us that there had been residents meetings in the past where choices were discussed, but that this had not happened for several months. This is an area of practice that needs to improve.

Staff confirmed that they felt well supported and that the acting manager had an open door policy. However the provider did not consistently ensure that staff were being suitably trained and supported to effectively meet peoples care needs. For example, the acting manager and some staff had not received recent training in MCA and DoLS and this meant that recent changes in the implementation and current best practice of the MCA and DoLS had not been fully understood.

Staff and the acting manager told us that supervisions, annual appraisals and training were not regularly taking place and that best practice in many areas needed to be revisited. For example, the reporting and recording of incidents was an area that staff needed to improve their understanding and practice in. The awareness of fire safety and the importance of carrying out fire checks and highlighting areas of concern was also an area for improvement, and had contributed to fire safety concerns not being fully addressed before the inspection.

Staff told us that the home's inductions had not been consistently implemented. Some staff had NVQ

qualifications but no recently employed staff had begun their care certificate. The Skills for Care certificate is a set of standards for health and social care professionals that ensures that workers have the safe introductory skills, knowledge and behaviours to provide compassionate, safe, high quality care and support. The acting manager was aware of gaps in training and the impact this had recently had on fire safety, medicines administration and moving and handling. In response the acting manager had arranged for a regular rolling training schedule to take place to address these issues but this had not been fully embedded.

Staff told us that team working had improved since the acting manager had been in post and communication was improving. This was demonstrated through the daily communication systems including handovers, communication books and notes that detailed health appointments and changes in people's needs. For example, staff were concerned that one person may have an infection and it was noted for a sample to be taken and the result confirmed in a timely way. A health professional also told us that staff were contacting their colleagues more regularly and asking their advice on how to record health records more robustly. They told us, "The care is more person focussed, staff are asking my colleagues about the correct way of doing things". "Things are much better; relationships with our team have really improved. We also observed the acting manager discussing a handover with staff. Each person was discussed to ensure that staff were aware of any key changes or important information to enable them to provide safe care and support to people. Staff were heard to be openly contributing to discussions at handover. The acting manager showed us a 'handover book' that they had implemented. These documents ensured information about people's care needs and wellbeing was current and shared within the team.

At the last inspection in January 2017 parts of the accommodation were not well decorated clean and hygienic. At this inspection the home was continuing with a programme of redecoration and improvements. The provider had replaced washing machines and purchased cleaning equipment to help maintain the environment. A regular visitor to the home told us, "It's cleaner and greatly improved since the acting manager has been here". On the third day of the inspection the bedrooms and communal spaces were welcoming, clean and without odour. Staff told us that one large lounge space had previously been full of chairs that faced the TV but that the acting manager had opened the space up recently by moving chairs, so that people using mobility aids could access the space more independently. We observed staff supporting people to practice using their mobility aids and supporting people sensitively and at their own pace when transferring to chairs safely. One person who had a sensory loss had access within their room to visual table mats so they could see where items were placed. In addition, they had access to audio books as they had previously enjoyed reading.

Good

Is the service caring?

Our findings

People were cared for by caring staff. People and their relatives told us that staff were caring and kind. One person told us they felt staff were very caring and dignified when it came to looking after them. Another told us, "The staff are very caring and supportive". A relative told us, "It's not the Hilton, but I'm over the moon with the care they get".

At the January 2017 inspection we found that peoples' right to privacy was not fully promoted as people did not have keys to lock their own rooms and communal bathrooms doors were not able to be secured by people wanting privacy. At this inspection we found privacy and confidentiality were respected. People told us they had a key to their rooms and where people did not want a key this was noted on care plans. Bathrooms were now able to be secured. Staff told us they supported peoples' dignity by ensuring support was given in a private space, asking consent and encouraging people to do as much as they could for themselves. We observed staff knocking on people's doors and waiting for consent to enter. Privacy, with regards to the information held on people's care plans, was promoted and records were stored in locked cabinets in the office. People, relatives and visitors were consistently positive about how caring the current staff were. People appeared comfortable with staff and other people; they initiated conversation, shared humour and discussed their plans for the day. Where people were more reserved or spent time sleeping, staff would sensitively check if they were awake and if they needed a drink or wanted to take part in an activity. One staff member checked if one person wanted their soft toy and then brought it to them from their room. The person received this happily and spent time holding it, whilst observing what else was happening in the room.

Staff told us and demonstrated that they had a good knowledge of people's needs, likes and dislikes. People and relatives told us that there had been a turnover of staff and that they had noticed lots of new faces more recently. However many of the new staff had experience of working with older people including people with dementia and were building good relationships with people. The acting manager was very visible in the communal space and had established a good relationship with people and regular visitors and relatives.

Visitors and relatives told us that they visited regularly and were always welcomed by friendly staff. One relative told us, "They are friendly, and obviously on good terms with my relative, it feels like a family run business". Another relative told us they were comfortable sitting in their relative's space privately or spending time in communal areas chatting with other people and staff.

Relatives told us they were involved in the initial care planning when the person was placed at the home and in the reviews of their ongoing care and support. They told us they were informed about changes involving their wellbeing when they had the right to be involved. One relative told us, "They are always nice and listen to what my relative has to say". They gave a recent example of how staff had provided additional meals to the person as they were feeling low and had lost their appetite in response to an anniversary they found upsetting.

Peoples' individuality and differences were respected and personal spaces were personalised to meet

individual needs and preferences. For example, one person who had had a military career had magazines and pictures relating to this in their room. People had their own furniture and personal belongings and family pictures in their rooms. Staff told us that one person had brought their musical organ from home so they could continue to play the instrument. People were able to maintain their identity; they wore clothes of their choice and could choose how they spent their time. One relative told us that their relative chose to spend time in there room, and had made a decision that she did not want to socialise in the communal spaces. While other people told us that they spent most of their time out and about.

Peoples' independence was encouraged where it could be. Some people were very active in their local communities and could leave the building and use transport independently whilst other people were more dependent on the support of relatives and staff to access day to day activities. Staff told us that they promoted peoples' independence by making sure they were happy with their choice and not taking over the activity. One relative told us that staff were encouraging their relative to walk more within the home, and another told us, " My relative needs the support of two people with their care needs, as soon as they went to the home and this happened, they physically perked up".

Peoples' diversity was respected and their religious beliefs detailed in their care plans. One person had chosen the home as it was close to their regular place of worship and they remained very active in their community. People who could not visit their place of worship were also supported. A relative told us "The pastor visits my relative on a regular basis, which is important to him as he is deeply religious".

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they felt listened to by staff and involved in the regular decisions and choices about their care and support needs. People told us that they could make choices about activities and how they spent their days. Staff told us that they understood people's needs and had positive relationships with them and their relatives. A relative told us that they had been involved in the planning of their loved one's initial care plan after they had spent some time in hospital and felt that their loved one's health had greatly improved since being at the home. They told us, "They are more like their old self". However we found that people were not consistently supported with personalised care and support plans did not always inform staff of how to respond fully to people's needs.

Some people had a lot of control over what they did during the day; they accessed activities in the community and were actively involved with their care planning. One person told us that they had visited the home and chosen what room they wanted. They told us, "I've got the best room in the house". They felt very happy and comfortable in the home. However some people had less control over their lives due to their mobility or dementia needs and were more reliant on good personalised care and support plans being available to detail their preferences and guide staff. Care plans had been reviewed recently but consistently only gave general information about people's likes and dislikes, personal life histories, health needs and initial risk assessments including those for nutrition, skin integrity and mobility needs. For example, where people had medicines noted on their care plans; there was no information about what the medicines were for. Moving and handling assessments had tick box responses that noted if people needed light or full assistance but there was no guidance explaining to staff what they needed to do to ensure personalised, consistent care. People's dementia needs were not fully discussed; there was no detailed information about how people's dementia presented or guidance to follow if, for example, someone became distressed. There was a system in place where care plan files of people living with diabetes had red stickers. However within the file the guidance given stated, 'soft diet, food cut up, diabetic'. The guidance given to staff in care plans or in the kitchen was not detailed enough to ensure their diet complimented their diabetic needs. This did not ensure that their individual needs were communicated or that risks to their health and wellbeing were suitably minimised.

Staff demonstrated that they promoted some positive outcomes for people living with dementia. We saw that people were kept informed about what would be happening next during the day, and given choices about whether they took part in joint activities or spent time in quieter spaces. Staff took time to explain options to people and gave them sufficient time to consider what they wanted to do as well as supported them to achieve this. We observed and people told us, that people, relatives, health and social care professionals were involved in developing initial care plans. Staff gave examples of how they promoted people's independence and we saw people being encouraged by staff to carry complete mobility transfers as independently as they could.

However, care plans did not reflect that people were being consistently encouraged to develop skills, set goals and increase their levels of independence. Staff told us that the care plans were improving but still lacked detail and were not as person centred as they could be. This did not ensure that people's care and

treatment was personalised specifically for them or based on an assessment of their needs and preferences. The acting manager told us that they were aware of this and had started to work on reviewing all the care plans to improve the level of detail. They were introducing a person centred planning tool so that people's life histories and interests were promoted. The acting manager carried out pre-admissions assessments for new people to help ensure the home could meet their needs. The acting manager and a health professional told us that in the past some people's needs had been assessed as suitable when in reality their needs were higher than the home could provide; this had meant that their needs had not always been met. A health professional told us that the registered manager had accepted some people with end of life needs that the service was less suited to provide. They also told us that since the new acting manager had been in place they had greater confidence in the decisions that were being made in relation to placements at the home. They also confirmed that as a result of this less people were being admitted to hospital from the home. However, to ensure that these initial signs of improvement are embedded and sustained. We recommend that the provider seeks guidance from a reputable source with regards to care planning.

People's personal interests and chosen activities were encouraged and supported where they were known. For example, one person regularly was visited by their relative and their dog. Care plans discussed personal interests and preferred one to one activities. Relatives told us that staff were very supportive of ensuring that people were ready when relatives were supporting them to go out. One person found it difficult at times that they could not just go for a walk independently and staff would either contact the relative who lived close by or spend time outside with them.

People told us that they missed regular activities taking place and that a residents meeting had not happened for several months. On the third day of the inspection a singer visited the home to entertain people in the lounge. People enjoyed this and were engaged with the music and singing and the event drew a large group. But this was not part of a regular schedule of activities. The acting manager told us "I encourage staff to do lots of social support, including puzzles and word searches. I talk to people about their views and encourage staff to chat with them and to involve people in everything". Individual activities were noted in people's daily records but it was acknowledged by staff and the acting manager that planned activities was an area that needed to be improved.

People and relatives were not consistently made aware on how to make a complaint about their care and support. People and relatives told us that they would speak to someone and would be happy to raise any issues they had with staff or the acting manager if they had concerns but they had not received information from the home on how to do this. One person told us of a complaint they made when they had been unhappy with their call bell not working, they had raised this and this had been checked, but they were not happy as sometimes it worked and other times it did not. This complaint had not been noted in the complaints file; however, the person did not feel they had been listened to by management. In response to this concern the home has advised us that the call bell system is checked weekly and they are looking into purchasing another system. However there were inconsistencies in how complaints were promoted, investigated and addressed by the home. The complaint file demonstrated that not all complaints were being recorded, for example, the concern raised by a family in relation to the significant medicines incident in March 2017 was not noted. When complaints were recorded very little detail was given about the concern, actions taken and any lessons that the home could take forward to improve practice. This is an area that needs further improvement.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in January 2017 the provider did not have effective quality assurance systems in place. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because their governance and quality assurance checks had not been effective in resolving a number of problems in the running of the home. Management audits and checks had not identified that people were not always protected from the risk of falls or not having enough nutrition and fire systems were not suitably managed. The homes environment was not always suitably clean, people's privacy was not always promoted and medicines errors had not been identified and acted on. The registered manager submitted an action plan in February 2017 to say how the breach would be addressed.

At this inspection some recent improvements had been made and people's nutritional and privacy needs were being met and promoted and the cleanliness of the home was also improving. However, not all of the providers' actions had been completed or embedded and we found additional and continued areas of practice that were not well led. Environmental risk assessments, audits and a programme of regular health and safety checks were not being carried out to help ensure risks were identified, communicated to staff and the potential for harm minimised through consistent safe practices. Peoples' medicines were not always managed safely and the principles of the MCA were not being consistently adhered to placing people at risk of being deprived of their liberty without the legal safeguards and authorisation for this to happen. In both incidences there was an absence of management oversight in relation to the concerns we identified. Although the acting manager told us this would be addressed, the provider and their quality assurance and assessment systems had failed, prior to this, to give consideration to making applications for DoLS authorisations for people who did not have capacity.

During the inspection the provider was unable to locate several documents that would inform how they managed the safety of people and quality of the home. This included the staff training schedule, medicines audits from November 2016 and accident and incident records from 2011 up until June 2017. Throughout the course of the inspection records could not always be located, for example the MCA and DoLS policies were not consistently available. This demonstrated that the provider did not have suitable systems in place to ensure that documents were retained securely and complete or that they were able to mitigate the risks relating to health and safety and the welfare of people and others.

In June 2017 the Food Standards Agency had rated the home as satisfactory in response to a visit where they found issues relating to the monitoring of out of date food and poor management of fridge temperatures. Previously the provider had performed well against the ratings. They also identified that areas of the kitchen required cleaning and better ventilation and better monitoring of the catering facilities by the registered manager. A return visit to the site by the agency in July 2017 confirmed improvements had been made. However at the initial stage of our inspection we noted concerns about the cleanliness of the kitchen and again foods not being dated suitably. This demonstrated that the provider had failed to embed the improvements previously made.

The provider's quality assurance systems and processes were not always robust and failed to protect

people. Without suitable governance systems in place to monitor the quality of the home the provider failed to recognise that aspects of the home were continuing to deteriorate. For example, at the initial stage of the inspection we noted concerns about fire safety; these issues had been addressed by the end of the inspection.

At the previous inspection fire safety was not carried out in a suitable way. At this inspection there were still significant gaps in how the provider approached fire safety and addressed actions from its own fire risk assessment. We observed poor practice in relation to fire doors, some were propped open and one door leading to the laundry room had been poorly aligned and could not close sufficiently to reduce the risk of a fire being able to spread quickly throughout the building. This was an area of risk noted on the home's fire risk assessment and was discussed with the acting manager. During the inspection CQC contacted the West Sussex Fire and Rescue Service (WSFR) to report their concerns. The WSFR service attended the site twice to ensure that the provider was meeting its responsibilities under the Reform (Fire Safety) Order 2005. Initially they found that the provider was failing to make appropriate fire safety arrangements including the monitoring and review of general fire precautions required, following the fire risk assessment. Several areas of action were required and the WSFR service returned to the site to confirm the concerns were suitably addressed in late October 2017. By the end of the inspection we saw evidence that the provider had addressed the fire report concerns. The deficiencies in the fire doors had been addressed and staff told us they were more aware of fire hazards such as furniture on landings and had completed training in fire safety.

The provider in relation to the safe management of food safety and fire safety systems had been dependant on the actions of other parties for example the CQC and West Sussex Fire and Rescue Service (WSFR) to identify and prioritise actions before they addressed significant risks. The provider did not have systems and processes to effectively assess, monitor and improve the quality and safety of the home. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The home did not have a registered manager in post. The previous registered manager had left the home in early August 2017. The acting manager had made the decision to apply to become the registered manager and was supported by an established senior staff member. Staff told us there was more structure in the home but this was not demonstrated through clear lines of accountability and responsibility being embedded in management structures. The provider was very positive about the acting manager's skills and previous experience of being a registered manager, and told us that they believed the acting manager had the skills necessary to address the poor practices in the home. The provider and the acting manager told us they were working to implement and embed a system of audits and quality assurance processes, to ensure there was more robust monitoring of the home and its practices.

The acting manager was open and transparent about what they knew and did not know in relation to the home, it's recent history and policies and procedures. However, provider and previous registered manager did not demonstrate that they understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). The provider and registered manager had not consistently submitted notifications to us as is required by regulations. The CQC had not received any statutory notifications from the provider since November 2016. However, prior to and during the inspection, we were made aware of at least two incidents that fell under the criteria for notifications of other incidents that had occurred since this date. One incident that should have been notified as a safeguarding incident occurred between March and May 2017 and involved a medicines error which was investigated by a health professional as a significant event. Another involved an incident in May 2017 where a person went missing and the police were involved in finding them safely. The acting manager did not know about this incident and was not clear what action had been taken. The provider and previous registered manager failed in their duty to investigate incidents, protect people from harm and to notify the CQC of incidents involving police action or any abuse or

allegation of. This is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 and will be dealt with outside of the inspection process.

The provider acknowledged that they had not had full oversight of the home as it continued to deteriorate. They had worked on the basis that the registered manager had quality assurance and management tasks in hand, and had been reassured that actions were being taken when they regularly met with the registered manager. They recognised that they would need to have more oversight of quality assurance systems in future and told us that they would be drawing up an action plan with the acting manager to address areas of poor practice discussed at the inspection

People and relatives spoke positively about the home and the staff and were building good relationships with the acting manager. One person told us that the previous registered manager had been good with helping them with their mobility needs, "But was not cut out to be a manager". A regular visitor to the home told us, "The home has improved since the acting manager arrived." One relative also spoke about improvements that had been made by the acting manager. For example, the lounge layout was more accessible, people had more food choices and afternoon tea was now a regular event.

Staff also spoke positively about how the acting manager was leading the home. One staff member told us, "It's improving here, the staff are calmer, have routines and the acting manager is great. They are fair and down the line". Another told us "It's a joy to come to work now since the acting manager came."

The provider regularly visited the home and the acting manager told us that they were, "Very supportive" of what they were trying to achieve and that they could "Pick up the phone to them if they needed advice or guidance". A staff member told us, "The provider is good, if I speak to them, they listen". The acting manager told us that they were encouraging a more open and transparent culture and the staff and acting manager demonstrated this through their actions. We observed a friendly and approachable staff team who communicated positively and openly with each other, with people and their relatives. One staff member told us, "The acting manager is approachable and very nice, I can talk to her and we trust her". The acting manager was also aware that the value base needed to be more people- focussed and was working with staff to encourage this by being open to questions, being involved with handovers and addressing poor practice when seen. Staff told us that the provider's values and aims were to, "Make people happy, comfortable and have fulfilling lives".

The acting manager told us that they were keen to inform best practice and develop links with a local community psychiatric nurse (CPN) and District Nurse. They planned to invite these local professionals into the home to provide additional learning support to the staff to enhance their knowledge and skills regarding supporting people living with mental ill health and physical health needs, including catheter care. A health professional told us that there had been noticeable improvements in the contact between the home and other health professionals in recent weeks. For example, the acting manager was meeting people and participating in assessments and involving other health professionals who could inform the support planning.

Satisfaction surveys involving relatives and people were completed in October 2016, which provided people and relatives with an opportunity to feedback about the quality of the care provided. The survey outcomes were consistently positive. People said they were happy with the care they received. Relatives also spoke about a planned Christmas carols event for people and their relatives to join so that staff and relatives could develop relationships and people could participate in the wider community.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that care and treatment of service users was provided with the consent of the relevant person as they had not worked within the principles of the MCA by assessing capacity and ensuring the legal safeguards such as DoLS were in place when required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people were provided with safe care and treatment by assessing and mitigating risk to service users health and safety or ensuring the safe and proper management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The Provider had not ensured that service users were protected from abuse and improper treatment by investigating immediately on becoming aware of, any allegation or evidence of such abuse.

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the quality and safety of the service was assessed , monitored and improved, or that risks relating to health and safety were assessed and monitored to mitigate risk.

The enforcement action we took:

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