Larchwood Care Homes (South) Limited

Alexander Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Alexander Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

The home provides accommodation and support for a maximum of 47 older people. People who are living with dementia are accommodated on the first floor. Each floor has adapted facilities for bathing or showering as well as sitting and dining areas. There is a lift for people to move between floors and a secure and accessible garden at the front of the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection took place on 19 October and 1 November 2017. The first day of the inspection was unannounced. At the time of our inspection, there were 42 people living at Alexander Court.

At our last inspection in January 2017, we found that the service required improvement overall. There was one breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 meaning the service was not as effective as it should be. This was in respect of people's nutrition and hydration and making sure people had enough to eat and drink. After that inspection, we asked the provider for an action plan to show what they would do to meet the regulation.

At this inspection, we found that there was no longer a breach of regulation 14. People had enough to eat and drink to meet their needs and keep them well. However, other aspects of the effectiveness of the service had declined and remained in need of improvement. Staff were not renewing their training promptly in line with the provider's own expectations. They lacked regular, formal supervision in line with the provider's expected frequency, to monitor their performance and development needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 for staffing arrangements.

We also found variable practice in promoting people's rights in accordance with the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). Some care was planned well to consider people's capacity to make specific informed decisions. Other people's care records did not show proper consideration of the MCA. We were concerned that restrictions imposed upon one person were not properly considered in line with the code of practice for DoLS. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 for consent.

The service was no longer as safe as it should be in all areas, representing a decline since our last inspection when the safety of the service was rated as good. Assessments of risk, including those associated with falls

and mobility, were sometimes conflicting. Some information was missing so staff lacked guidance about mitigating risks to people's safety. There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 for providing safe care and treatment.

Some aspects of the leadership and management of the service had not improved since our last inspection. They remained in need of improvement. The registered manager had not addressed issues highlighted in the provider's own quality assurance reports consistently or promptly. Neither the provider's systems for monitoring quality and safety, nor internal checks by the management team, identified the issues our inspection team found. The history of the service showed that the registered persons had not always sustained previous improvements. We were concerned that there was no exploration of possible intimidation between members of staff affecting the quality and continuity of care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 for good governance.

You can see what action we have told the provider to take at the back of the full version of the report.

When people had experienced sustained an injury, for example after a fall, staff sought emergency treatment and advice promptly. There were updates to their information and an exploration of any factors contributing to falls. In addition to emergency advice staff also followed up concerns about people's health or wellbeing so people could see relevant health professionals.

Staff understood their obligations to report concerns that people were at risk of harm or abuse. Recruitment processes contributed to protecting people from the employment of staff who were not suitable to work in care. Staffing levels were under review and monitored to ensure people could be supported safely.

Staff understood how to manage medicines in a safe way and the management team addressed the few concerns we raised promptly.

The service remained caring. Staff, despite being busy, supported people in a compassionate way and were respectful of people's dignity and privacy. They understood people's likes and dislikes for the way they were supported.

The service remained responsive to people's needs. Although care plans did not always guide staff about specific aspects of care, staff understood the support that people required to meet their needs. They also knew how people liked to spend their time and what interested them. There was some room to improve people's day-to-day activities to take into account their interests. However, we noted that there were temporary absences of the staff dedicated to deliver the programme of events.

People were confident that their complaints would be addressed and there was a proper system for responding to these. The process included letting people know about the investigation and findings and how their complaint would be resolved.

People were asked for their views, but there could be improvement in the way they were involved in discussions about the action taken or informed what was being done to address their suggestions. The registered manager was considered both approachable and amenable by staff and people's representatives if they needed to share information.

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 always safe.

There was a lack of consistent and clear guidance for staff about minimising risks and in some cases, a failure to assess risks.

Measures to prevent and control any outbreak of infection needed to improve so that people were protected.

Medicines were largely managed in a safe way and with prompt action taken when we highlighted issues at inspection.

Recruitment processes contributed to protecting people from unsuitable staff. Staffing levels and duty rosters were subject to review to ensure people were safely supported.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always supported properly through supervision and did not always complete training in a timely way.

There was variable practice in assessing people's ability to give informed consent to specific decisions and in proper consideration of restrictions on freedom.

People were supported to eat and drink enough to keep them well.

Staff ensured people were able to gain advice and support from health professionals about their wellbeing.

Is the service caring?

Good

The service was caring.

Staff supported people in a kind and compassionate way.

People's dignity and privacy was respected.

Is the service responsive?

Good

The service was responsive.

Although people's care records were not always clear, staff understood people's needs and preferences.

People or their representatives, were confident any complaints they made would be listened to and addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems for evaluating the quality and safety of the service were not robust enough to identify all areas for improvement.

Where processes did highlight improvements to meet the provider's expectations, these were not always made promptly.

Improvements made were not always sustained.

People were asked for their views but improvements could be made in ensuring they received feedback about the action being taken.

The registered manager was approachable and accessible.

Alexander Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was also prompted in part by notification of an incident following which a person using the service sustained a serious injury. It was brought forward from the intended date so we could examine potential concerns about the management of risks in relation to falls.

The inspection took place on 19 October and 1 November 2017. The first inspection visit was unannounced. It was completed by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed all the information we held about the service. This included information about events taking place within the service and which the registered manager has to tell us about by law. We also reviewed information that members of the public had submitted to a care home review website to assess their feedback.

During our inspection, we spoke with four members of the care team, the administrator, operations manager, registered manager and deputy manager. We also spoke with eight people using the service and three relatives. We observed and listened to how staff interacted with people. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records for eight people. This included assessments of their needs and risks, for example associated with mobility and falls. We checked how people's medicines were managed in both sections of the home.

We examined three staff recruitment files, training records for the staff team, minutes from staff meetings and the supervision and appraisal schedule for staff. We checked a sample of records relating to maintenance of the premises and equipment. We inspected a selection of information relating to the quality

and safety of the service. This included audits completed by the management team and the provider's representatives and the minutes of meetings with relatives and people using the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of this service on 24 January 2017, we found that the safety of the service was good. At this inspection, we found that aspects of safety required improvement.

There was variable and inconsistent practice in assessing risks to people's safety and in guidance for staff about minimising these. There were some risks that an outbreak of infection might not be possible to control robustly.

People who needed to use the hoist and slings to assist with mobility did not have their own slings but shared them, including toileting slings. One staff member said that slings were washed regularly but they were unsure whose responsibility this was and how often it should happen. We discussed with the registered manager and operations manager that there was a risk that any outbreak of infection would be very difficult to contain in these circumstances.

We also found concerns for cleanliness and infection control in one of the treatment rooms used for storing medicines. There was an exposed area of porous concrete and a damaged edge to the floor covering where a cupboard had been removed. This meant that staff could not clean the floor properly. There was a hand basin for staff to wash their hands before or after administering medicines. This was stained and not clean.

In the same room, there was an exposed cavity into the wall space where water supply pipes were not properly boxed in. This meant that dust and debris could accumulate and harbour germs. It also presented a risk that any fire, potentially electrical, breaking out in that room, would not be properly contained.

Two of the sets of care records we reviewed contained clear and detailed assessments of risks to people and how staff should support them safely. However, for the remainder, there was incomplete or unclear information for staff about supporting people safely with their mobility and transfers. Assessments of risk relating to falls, dependency and mobility were sometimes contradictory. Inconsistent or absent information presented a risk that people could experience unsafe care.

For example, for one person, their dependency assessment showed that they needed assistance to mobilise, requiring a 'stand-aid' and support from two carers. Other records, including their moving and handling assessment and information about how they transferred to and from a chair, reiterated the use of this equipment. Their care plan for mobilising and falls did not refer to using it. We saw that staff assisted the person to transfer from an armchair to wheelchair without equipment.

Staff explained that the person did not need to use the 'stand-aid'. They told us how they assessed the person's wellbeing each time they offered support, so they knew when they could transfer safely without the equipment. However, we were concerned that records did not provide consistent and accurate guidance for staff. The plan for their care and assessment of risk contained conflicting information, did not reflect the person's current level of risk accurately or guide staff about supporting them safely.

One staff member used a technique that was not safe, positioning their forearm under the person's armpit to help them stand. This was potentially unsafe for both the person and the staff member themselves.

Another person's records showed that they had a history of falls but the assessment form used for detailed recording of falls risks was blank. This meant that staff had no proper guidance about risks and minimising them. The falls prevention service had visited the person in March 2017, but there was no clear information within their records to show the advice given about the person's safety. The person's assessments of how they transferred safely lacked clarity. They needed one staff member to help them move from sitting to standing, and to transfer to and from their chair. However, guidance also said that the person needed two staff to help them transfer to and from their bed. We observed that the registered manager assisted the person without other staff support, from lying on their bed to sitting in their armchair. This was inconsistent with information stating they needed two staff to assist them in transferring to and from their bed.

For a third person, information from the authority arranging their placement was not used to plan safe care for them. The information supplied about them showed that, because of their medical condition, they could "freeze" when they were mobilising. It said if that happened, the person would need assistance of two or three staff to get them moving again. It also showed that the person was at risk of falls associated with sudden changes in their blood pressure. However, the home's assessment and planning to meet these needs safely, was incomplete. Their moving and handling assessment had not been completed at all although they had been living at Alexander Court for more than two months. The person's care plan for mobilising and falls contained only a heading and the remainder was blank. There was therefore no guidance for staff about supporting the person safely.

We showed the registered manager samples of the information we were concerned about. He agreed that the information was not complete and was inconsistent.

We saw that staff had referred a person to the falls prevention service for advice before they experienced a serious injury and had been waiting for their advice before they fell. We asked about the provider's policy around falls and the trigger point for referring to the falls prevention team. The registered manager told us they should make referrals if people experienced three falls in 12 months. This had not happened. The provider's project manager visited the service on 12 October 2017 and identified in their report that the home had missed this trigger for the person concerned. This was consistent with our concerns. The report also said that, "Falls topic supervision to be undertaken ASAP." This was to help increase staff awareness about falls prevention. It had not happened since 12 October 2017 when the project manager visited and left a copy of their report. Up to the point of our second inspection visit on 1 November 2017, this action remained outstanding.

These concerns represented a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

However, we could see that this person's care plan contained clear information about risks associated with their mobility. Their care records showed that staff had sought additional advice about presenting risks. The records confirmed that that staff had discussed possible factors contributing to the person's frequent falls with a selection of health professionals and the person's family. This included input from the GP to explore the option of purpose made footwear and the podiatrist to check their feet. The community psychiatric nurse was also involved and asked to assist with advice about managing anxiety or restlessness. Staff had put a pressure mat in place to alert them to the person moving about at night-time to contribute to the person's safety. They had also sought medical advice promptly, including from emergency services, following falls.

For the person without proper assessment or care plan for mobilising and falls, likely to "freeze" when mobilising, staff had spoken with the person's GP. Staff had identified the person's mobility was deteriorating and they needed advice about supporting the person more safely. Records about the medical appointment showed there would be a referral for further specialist advice about the person's underlying health condition.

We also noted that, after the visit from the provider's project manager, the deputy manager had completed a detailed audit of falls for individuals and the frequency with which these happened. They had ensured they made referrals more quickly, including repeat referrals for people who continued to be at high risk and experience falls. This contributed to ensuring that the right advice was obtained or updated where necessary.

Although there were shortfalls in the assessments of risks for individuals, risks around the home were assessed and largely managed in a safe way. The maintenance person ensured that they tested equipment for detecting and containing fires regularly. However, we noted that their records showed it had taken a period of over five months to rectify faulty emergency light fittings, although these were now working. We raised with the registered manager and operations manager that concerns about failures in such emergency equipment need to be addressed quickly.

Staff participated in fire drills so that they would know what to do in an emergency. Hoists and the lift were checked regularly to ensure they remained safe to use. Electric and water services were maintained and checked to ensure that they were functioning appropriately and were safe. On the second of our inspection visits, we found that the safety of the gas supply and equipment was slightly overdue for servicing. The registered manager arranged for this to happen promptly when we raised it.

People expressed varying views about whether there were enough staff to meet their needs, but they did not feel they were unsafe because of it. For example, one person said, "I'm not sure if there's enough staff here. When I need help they can take quite a long time if they're helping another resident." A second person told us, "If they're busy with someone else and you press the bell, you can easily wait ten or fifteen minutes." However, another person commented, "We are very well looked after here. If staff can't get to me quickly they'll let me know they're dealing with somebody else before coming to see me." They went on to explain, "Well they can't be in two places at once. Normally they're pretty quick if I press my bell."

We found that there were some times of peak demand where it was difficult for staff to attend to people's needs as quickly as they may wish but that staffing levels were safe. The deputy manager and registered manager provided some direct support and assistance during shifts on both of our inspection visits where there were shortfalls. Staff worked well together to respond to people's needs and some staff came in early to provide cover for colleagues who were unwell. During our second inspection visit, we needed to use the call bell on behalf of one person. Staff responded quickly to the call bell.

Staff told us that, although there were times of high demand such as first thing in the morning they felt staffing levels were safe. We spoke with the registered manager about how they assessed staffing levels to ensure people's safety. They showed us the provider's detailed dependency assessment used for calculating the hours required. They reviewed it regularly. They confirmed that, based on this tool, the right numbers of hours were provided. The registered manager and operations manager recognised that it was of benefit to have an additional staff member on duty at night. They showed us how sometimes there were five night staff on duty but this was not always sustained.

We discussed that the management team should consider further whether the layout of the building

affected the assessment of staffing levels. We also raised the issue of assessments of individual risks being either contradictory or incomplete. This meant that there was the potential for underestimating the staffing levels needed. The registered manager and operations manager confirmed they were reviewing duty roster arrangements and would be consulting with the staff team. They said this was to establish whether any changes in core shifts would better enable them to address times of peak demand.

Staff were recruited in a safe way. Records included the information the law required for staff appointed. This included full employment histories and references. There were also enhanced checks on people's backgrounds with the Disclosure and Barring Service (DBS). DBS checks verify whether applicants have any criminal records and whether they are barred from working in care services. This contributed to protecting people from the employment of unsuitable staff.

People told us that they received their medicine when they needed to. For example, one person's relative said, "They give [family member] her pills and make sure she takes them." Other people confirmed this was the case. There were some concerns for the safe management of medicines. However, the majority of people received their medicines as the prescriber intended and concerns we identified were put right promptly.

We found an anomaly in medicines for one person. They had two medicines containing the same drug ingredients but one was designed for a modified release rate. A check on the available medicines showed an error in staff following the prescriber's directions. The deputy manager addressed this with the person's GP promptly when we raised it. They obtained a prescription to address the deficit of one of the medicines and checked that the person would not experience any ill effects. Between our first and second inspection visits, the competence of staff administering medicines during the period in which the error had occurred was reassessed.

We found one missing signature from a person's medicine administration record (MAR) suggesting they had missed a dose of their antibiotic medicine. When we checked the medicine packet, we found that they had missed a dose. Staff had not identified the missing signature on the MAR at two subsequent checks so that the management team could investigate. We raised this with the deputy manager who agreed to follow this up. They understood the importance of giving such medicines at regular intervals to treat and control infections.

We saw that staff administering medicines always checked the medicines for each person with their MAR and made sure people had enough to drink to take their medicines. There was one occasion where a staff member placed a person's tablets on the tablecloth beside them. They pointed out they were there so the person could take them when they were ready but then returned to the medicines trolley without further check. They could not therefore be sure the person had taken their medicines and not dropped one without realising.

However, two other staff members followed better practice on two other medicines rounds. They encouraged people gently to take their medicines and briefly explained what they were for. They checked sensitively and discreetly to ensure that people had taken their medicines before they signed the MAR to show successful administration. We also saw that, where one person requested pain relief, staff explained clearly the reason for a necessary, slight delay. This was to ensure there was a safe interval after their previous dose.

There were systems in place to help protect people from the risk of abuse. Staff confirmed they had training in safeguarding and were able to tell us what would lead them to be concerned people were at risk of harm

or abuse. They were aware of their obligations to report their suspicions and how to go about it. They also said that they were confident the management team would act to deal with concerns they raised within the home. We noted that there was a poster displayed reminding staff what they should do.

The registered manager was able to describe the process of referrals to, and liaison with, the local safeguarding team. They acted promptly to address one issue raised with us during our inspection and could explain how they had dealt with historical concerns to ensure people were protected as far as practicable.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 24 January 2017, we found that the effectiveness of the service needed to improve. There was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. This was because of concerns about how the service made sure people had enough to eat and drink. The registered manager told us what they were going to do to improve and we found they had taken action to meet the regulation. However, other aspects of the effectiveness of the service continued to require improvements.

People were generally satisfied with the food and drink on offer although staff could explore options for ensuring people were more aware of the choices available to them. One person commented about the food and said, "It's OK, it's a bit repetitive and if you don't like what's being offered they give you the rest and leave what you don't like off the plate." We asked if they could have something different if they did not like what was on offer. They told us, "I'm not really sure; I suppose they might make me a sandwich." Another person and their relative told us there were choices. They explained, "Staff are very good. Nothing is too much trouble. The staff know what [family member] likes and they'll get something if [person] asks."

On the first of our inspection visits, there was a roast dinner on the menu. Lunch was roast beef and Yorkshire pudding, roast potatoes, broccoli, cauliflower and gravy. No one was offered an alternative meal despite a person saying they did not want the roast meat. There was no alternative displayed on the menu board in the dining rooms. Staff told us that people could always have something else, like a salad. However, the menu boards did not say that so people might not be aware of it.

On our second inspection visit, there were alternatives both displayed and offered. We heard staff asking people which of two options they would like. We also noted that there had been some very recent changes to the menu, particularly at teatime. These corresponded to what people said at residents' meetings about what they would like to see on offer. We found that the provider's mealtime audit reflected that there were choices of main meal on offer. Increased clarity for people using the service was therefore needed so people were confident to request something else.

People had a cold drink with their lunch, either squash or water, and staff offered hot drinks afterwards. However, we noted that, with only one exception on the first floor, staff asked if people wanted a cup of tea and did not offer coffee. They told us that this was because they knew what people liked after their meals. A relative told us, "[Family member] gets offered lots to drink and they know her favourite is tea. I think they give her plenty to drink." We noted that one person, whose recorded preferences showed they liked hot chocolate, was offered this as an alternative.

People had drinks available in their rooms. However, one person who was able to pour this and drink independently, had their jug and beaker out of reach and told us they were thirsty. We rectified this but concluded that staff, including cleaning staff if they moved things, needed to be more careful about placing drinks for people who managed independently. We heard staff offering people drinks and biscuits regularly during the day.

Staff monitored people's food and fluid intake during the course of each day and records relating to this had improved significantly. The deputy manager checked, particularly in relation to how much drink people had consumed, whether this was enough. They liaised with people's GPs if there were concerns. A member of the care team explained what they had done during the summer's hot weather to ensure people remained well hydrated.

Staff were able to tell us who needed their food prepared in a particular way to aid with any swallowing difficulties. We saw that they offered people assistance to eat their meals if they needed it and offered encouragement to others.

Staff checked people's weights regularly to see whether they needed to make any additional interventions with their diet. The management team and operations manager confirmed that people's diets were fortified to aid in minimising risks of weight loss. We did have concerns about one person losing a significant amount of weight. However, this was recorded in two separate locations and the deputy manager was able to confirm there was an error in transcribing the information to their care records. The staff team were largely successful in stabilising people's weight and sought additional advice from a dietician or GP if they needed to.

Arrangements for staff training, support and development presented a risk that staff may not maintain their competence and be up to date. Support for staff through supervision so they could discuss their performance, training and development needs was inconsistent and not in line with the provider's expectations.

Staff told us that they had access to training, with some of this being e-learning and some being face to face. The home's administrator showed us how they monitored training. The systems highlighted the training that particular staff required according to their roles. However, one member of night staff, sometimes working as one of four staff on duty, had not completed training to safely move and handle people. We were told that they needed to ask other colleagues to carry out activities that required these skills. One of two staff we observed assisting someone to stand from an armchair and transfer to their wheelchair, also did not follow appropriate practice. They assisted the person to rise by using their hand under the person's armpit, which can present a risk of injury.

The provider's expectations for renewing time-limited training to ensure staff remained competent were not met. For example, one member of staff responsible for administering medicines, was due to complete an update to their training in March 2017 but this had not happened. We saw that 17 of the 45 staff listed, were shown as overdue to renew their training in first aid and basic life support. For 16 of those staff, including the registered manager, their training was due for renewal during 2016. It was at least a year overdue, based on the provider's schedule and expectations. This presented a risk that they would not be able to respond competently and confidently to people's needs in an emergency.

One of our inspection team noted that a person coughed during lunchtime becoming very red in the face. Staff encouraged them to move to the lounge and offered reassurance but did not check if they were choking or had food lodged in their throat. We asked one staff member whether their first aid and emergency training covered back slaps and abdominal thrusts to deal with a choking emergency. They told us they thought so but they were not sure and did not therefore present as confident to deal with such an event.

The provider's training schedule showed they intended that staff should update their training about supporting people who might lack capacity to make their own decisions. This same schedule showed that

both the manager and deputy manager were due to renew their training in 2015 and it was two years overdue. This presented concerns that they would not be up to date with best practice and latest guidance, and could not therefore support the staff team in this area.

We noted that the project manager's report from 12 October 2017 agreed there were shortfalls in training and advised the registered manager to "pack out" forthcoming face-to-face training sessions. The registered manager confirmed to us that additional face-to-face training had been arranged, including in care planning and in restrictive practices. One training session took place for a group of staff during our inspection. The provider's systems showed that training at Alexander Court fell significantly below their expected targets and was identified as a "red" risk at 66%. The operations manager told us the expected figure for completion was 85% and agreed the service fell well short of the standard.

Staff said they received support from their colleagues, senior staff and the management team. However, there was variable practice in staff receiving formal supervision and staff understanding and expectations of this. Supervision is needed as an opportunity for staff to seek support, discuss their performance and any development needs. One staff member told us that their supervision was once a year. We checked that they were not confusing this with annual appraisals but they assured us it was supervision and they had recently received theirs.

We discussed with the registered manager how often they expected staff to receive formal supervision. They told us that they tried to ensure this happened every two months. The heading printed on the schedule showed it should take place a minimum of six times each year. We reviewed the programme to see how staff were formally supported. We found that some members of the care team had received no supervision for over six months. We commented on gaps in supervision at our last inspection. At that time, we did not consider that it had a potential adverse effect on care and support for people. However, this had declined further and the provider could not be sure that staff remained properly trained and supported to meet people's needs competently.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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 MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff were aware of the importance of encouraging people to make decisions about their care and of seeking consent before they delivered care. We observed that this happened during our inspection visit. We noted that a staff member asked someone's permission if they could assist them with their meal. We also heard a staff member explaining to people what their medicines were for when they were assisting people with these. Staff knew that sometimes people's willingness to accept care would vary and that they needed to be flexible in returning to offer care at a different way or to see if people would accept support from a

colleague.

At our last inspection, we found that there was a thread of information running through care plans relating to people's capacity to make informed decisions about their care. At this inspection, we found that care plan information was in a new corporate format. Some information about people's capacity to make decisions about their care was not always well represented. Information was inconsistent and did not reflect a robust approach to protecting people's rights in all cases.

We noted that the operations manager identified the lack of assessments of mental capacity and people's best interests in quality monitoring reports for both August and September 2017. The provider's project manager identified in their October 2017 report, that there were some concerns about implementation of the MCA and that referrals were required under DoLS for some people which had not been made.

In all but two of the sets of care records we reviewed, there was poor or inconsistent information about people's capacity to decide on specific, individual aspects of their care. For example, one person's communication care plan said that they had no problems communicating and could understand what was said to them. Their records did not show, given their understanding, how staff provided essential information for them to evaluate it and make individual decisions. The person's dependency assessment contained a note that the person was not able to make any decisions on their own rather than reflecting separate and specific decisions. Their care plan for capacity and decision-making completed at the same time also stated the person had no capacity to make decisions except to let staff know if they needed the toilet. It went on to say that the person was inclined to give yes or no answers. This meant that the information lacked clarity about how staff could provide information in a way that was supportive of informed decision making as far as practicable.

The same person's care plan contained an agreement made with the person's relative to prevent them accessing their room at a specific time of day. A staff member told us that, in practice, their door was also locked at other times of the day to promote the person's wellbeing after their meals. They were able to explain in detail why staff did this, although it differed from the agreement on file. In relation to that agreement, it was appropriate to involve the family member who knew the person well. However, there was no confirmation that the relative was legally entitled to make decisions about the person's health and welfare. There was no assessment of the person's capacity to decide on their preferred course of action, or to determine what was in their best interests. Their care records did not reflect consideration of less restrictive options. We considered that, without appropriate assessment and decision-making processes, the action presented potential restrictions in their freedom to use their own room.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014.

Two other people's records reflected a good, clear consideration of their capacity to make specific decisions. These showed the individual decisions under consideration for each person. They related each of the assessments about the person's ability to decide, to specific aspects of their care. They showed how the people concerned were consulted and whether they could understand and retain information. They recorded who was involved in discussions about people's capacity, for example, relatives who knew the person well, or professionals responsible for care. Where it was determined that they could not make informed decisions, their best interests were taken into account so that their rights were protected under the MCA.

People were satisfied that staff supported them with their health and wellbeing and to access advice from

health professionals. They told us that local GPs made regular visits to the service and we confirmed this from people's records. One person said, "If I wasn't feeling well I'd stay in bed. I expect they'd call for the doctor if they thought I needed to see him." A relative told us, "I know the doctor comes here once a week but [family member] seems to be doing remarkably well and doesn't need much help with her health."

People's records confirmed access to additional advice where appropriate, such as occupational therapy, dietary advice, speech and language therapy and support with their mental health. District nurses also supplied support to people when necessary. People's care records showed that staff referred people promptly for their advice. However, we found that one person had continence aids supplied by their family and had not had a professional assessment of their needs from the continence advisor. During our inspection, a staff member undertook to arrange this to ensure the person had access to the right advice and products.

People said that their relatives arranged to support them with appointments at the dentist when they needed support with their dental care. They confirmed that a chiropodist visited the home regularly so they could have their feet cared for. We noted that, where a person became seriously unwell during our inspection, staff were quick to respond and seek emergency advice and treatment to promote the person's wellbeing.

Good

Is the service caring?

Our findings

At our last inspection on 24 January 2017, we found people received a good, caring service. At this inspection, there was one isolated exception relating to confidentiality that happened at a particularly busy time following an emergency. The vast majority of staff interactions with people were warm, respectful and friendly and staff displayed caring attitudes.

Relatives were confident in the caring interactions with staff. For example, one relative told us, "I've never heard anyone get cross. They [staff] are better than good, they're fantastic." Another relative said, "I think getting [family member] in here was one of the best things I've done for [person]. The staff are kind and helpful and nothing is too much trouble."

Other relatives reflected these views in the compliment cards they sent to the service and in published opinions on a care home reviewing website. For example, in recent reviews one relative had commented, "They [staff] treated him with such care and dignity." Another relative wrote, "I cannot thank the staff for all they did ... Every one of the carers made every effort possible to make sure he felt comfortable, cared for and loved. It has always been a welcoming atmosphere every time I visited. The staff do so much more above the normal physical and personal care. They care about every single resident."

During our formal observation, we saw that staff supported people at their own pace, for example when they assisted people to walk or with their meals. No one became distressed or anxious and there were no poor interactions from staff. Each person received the encouragement and support they needed. Staff maintained a calm and peaceful atmosphere, even during a medical emergency. Where one person had been anxious about a particular event, the management team could explain what they had done to address it and offer reassurance.

We saw that staff called people by their preferred names. We noted that staff did not use one person's given name. When we checked we saw that the person's preferences were recorded and staff respected them. When staff communicated with people, they got down to the right level and made eye contact with them. They offered gentle and reassuring touches when people needed this and were cheerful and friendly.

People were able to make choices about how they wanted their care delivered. For example, one person told us, "I don't like having a bath; I don't like the hoist so they give me a bed bath and wash my hair in here instead." Another person commented, "I can stay in bed if I like, I can stay in bed all day if I choose." Their relative said this was the case but explained to their family member, "You can, but they prefer you not to. They do try to get you to get up because it's not good for you to stay in bed all day."

People's choices included how they wanted their rooms arranged. For example, one visitor told us how their partner's room had been adjusted to reflect their interests. They explained that the person was very keen on all things to do with London Transport. There were many pictures and models of buses and trains in their room. The visitor explained, "We are trying to make this as homely as we can for [person]. I bought the pictures and shelves and the maintenance man put them up for me. He even sorted out additional lighting

and getting the wiring all tidied away. It has made a big difference to [person]. Since [person] been here their health has improved." A relative told us, "[Family member] can have this room the way she likes it. The staff were very helpful in getting the room just how she wanted it."

Staff were mindful of people's privacy and confidentiality with one isolated exception. One staff member discussed personal and sensitive information on the telephone in a dining area where others could hear. However, we noted that this was following a medical emergency and they needed to respond quickly to a telephone call with information. We observed that two people in their bedrooms on the first floor were not appropriately dressed or covered. They had their room doors open and so this compromised their dignity. However, staff intervened promptly and appropriately when we alerted them. We saw staff knocking on people's doors and asking permission before entering people's rooms.

Staff referred to people and spoke with them, in a way that was respectful and polite. Staff carried this through into the way they compiled daily records. These again were respectful and used appropriate language as they did in their discussions with us.

Good

Is the service responsive?

Our findings

At our last inspection on 24 January 2017, we found that people experienced a good, responsive service. At this inspection, we found this continued, although opportunities for activities were curtailed in the temporary absence of allocated staff.

People felt that staff met their needs. A relative told us, "[Family member] needs help because [they] wear pads. We were quite surprised when [person] came here because they check and change [person] much more frequently than the care home they were in before. I think that's good because [person] is less likely to get sore." Another relative told us that staff had all the equipment they needed to help the person to wash properly.

We found variable practice in how care plans documented people's individual preferences and guided staff to deliver care centred on each person's needs. Care plans did not always contain detail about people's preferred routines, likes and dislikes or whether people preferred care from staff of the same gender. However, although written information was variable in the detail it contained, staff spoken with showed a good understanding of both people's needs and preferences. Staff had developed an understanding of how people wanted their support delivered. One staff member explained how they had learned from working with people and with their colleagues. They could explain people's personal preferences and told us how they incorporated these into people's care. They gave us examples of whether people preferred a bath or shower and what they liked to wear or eat.

Before our inspection, we received information suggesting that night staff were expected to start helping people on the first floor to get up very early. We addressed this with the registered manager and operations manager. Copies of the registered manager and deputy manager's night-time audits showed that this did not happen. We could also see that the registered manager had issued written guidance to staff about expectations while reflecting people's preferences. Staff spoken with said that they tried to make routines flexible based on people's preferences. They were clear that staff worked as a team and that people got up as and when they wanted to. They explained that some people got up early as they had difficulty sleeping, while others liked to remain in bed. Staff knew where people liked to spend their time and what their interests were.

A relative told us, "There are trips arranged by the home. [Family member] went to the football at Norwich, about six or eight of them went on the train. They had a bite to eat … then went to some sort of charity match." People told us that there were outings but they would like the opportunity to do more activities that would interest them on a day-to-day basis. One person commented, "We used to do some singing and I like that but we don't do as much as we used to." A relative also said, "I do worry there's not a great deal to do." One person did tell us, "I'm not really that interested in the organised activities but there are some raised flowerbeds outside and I like to keep them tidy."

One person told us that the position of the home in the centre of town meant they were able to go out to church. Staff confirmed to us that the person did attend a church lunch club from time to time.

On the first of our inspection visits, we noted that one activities coordinator had been unavailable and the other was on holiday. The activities programme displayed was out of date. Staff said that they did spend time with people when they had the opportunity. We saw that they consulted with people about a film they wanted to watch during the afternoon. However, staff were too busy to organise any other group activities with people during our inspection visits.

The service operated a proper process for receiving and investigating complaints. People said that they would speak to staff or to the manager if they had complaints about their care. They felt that staff would address their concerns or pass them on if they could not deal with them. We noted that the management team dealt promptly with one concern raised with us and checked with the person concerned how they wanted this addressed.

Records showed there had only been two complaints during 2017. We found these were recorded, together with the investigation and outcome. We reviewed the information relating to one of them and saw that outcome was discussed with the complainant so they knew what had happened. We noted that the numbers of compliments received from relatives greatly outweighed the concerns raised. We discussed with the management team that it would be good practice to date letters and cards praising the service so they could better keep track of how many were received and when.

Requires Improvement

Is the service well-led?

Our findings

The history of this service is one of fluctuating quality. At inspection in November 2015, the overall rating for this service was good. At our last inspection on 24 January 2017, we found that the leadership and management of the service needed to improve, although there was no breach of regulation for leadership and governance. At this inspection, we again found concerns for how the provider and registered manager ensured people received high quality care. Neither the provider's systems for monitoring service quality, nor the 'in house' audits and checks, were sufficiently robust. They did not proactively identify the concerns we found during this inspection.

There was only one breach in regulations at our last inspection, and the registered manager submitted an action plan designed to both meet that and improve other aspects of the service. At this inspection, we found the breach of regulation concerning people's nutrition and hydration was addressed. However, other improvements were not sustained; there were additional concerns about the quality and safety of the service leading both to breaches of regulations and areas for improvement.

The action plan identified the registered manager's intentions to improve support through supervision for new staff members. At this inspection, we found that most new staff had received supervision. However, for other members of the staff team it was not taking place in accordance with the provider's own expected standards. The provider's training schedule identified those aspects of training staff needed to update through their e-learning. A lack of supervision compromised how the management team addressed and monitored staff development to ensure timely completion of training.

We identified at our last inspection, improvements were needed to the completion of care records for assessing risk and how staff should manage them. At this inspection, there were serious concerns that information about risk was incomplete or inconsistent and therefore inaccurate. Because of either omissions or inconsistencies, guidance for staff about mitigating risks was absent or contradictory. This included for people for whom there was a history of falls and information before their admission indicated high risk of falls. We showed the registered manager the omissions and inconsistencies in the documents that particularly concerned us. They agreed that some information was missing altogether from these records and others lacked clarity. Auditing processes had not identified omissions or inaccuracies in these records.

The registered manager told us that they found the provider's operations manager accessible to them. The operations manager, or one of the other provider's representatives, visited regularly and provided the registered manager with their reports about service quality. The reports showed whether there should be improvements and the action needed. However, we noted that the registered manager did not always take prompt action in response to the findings of the reports and as the provider considered was appropriate. In some cases, we saw the same area for improvement was identified at successive reports.

For example, the operations manager identified in their report from August 2017 that the specimen signature sheet for staff authorised to administer medicines was not up to date. The report said this would

be addressed by the end of the day. However, the operations manager's report from September 2017 showed the same issue. We also found inconsistencies in the record sheet, which was intended to make it easier to identify staff responsible for giving medicines. We found that, in one treatment room, two separate lists of staff names and sample signatures did not all correspond. The list in the medication folder did not match the list displayed on the treatment room wall.

The provider's project manager completed a monitoring visit on 12 October 2017. This identified that they considered medicines records should have photographs of people in them. We concurred with this view in that it would help to make administration easier, represent good practice and reduce the risk of error. However, we identified the same concerns in medicines records on both floors of the home. On the ground floor, we found that a folder containing information for 12 people contained pictures of only five of them. On the first floor, three weeks after the project manager's visit, we found that a folder contained information about medicines for 11 people. Only four had photographs to act as a reminder for staff and help them in identifying people when they administered medicines.

We saw that the registered manager had addressed concerns that people were being assisted to get up too early in the morning. They had provided both written instructions to staff and raised it at staff meetings. The registered manager had arranged for a senior carer from day shift to cover nights temporarily and to feedback how shifts were operated. They explained this was because they considered the staff member's organisational skills to be good. They had identified inconsistent quality of support and felt that this exploration of the issues would help identify they could ensure practice was more consistent.

Staff on duty during our inspection visits, told us that teamwork and morale was good. However, we identified concerns in minutes of a staff meeting on 20 September 2017. These recorded the view that some staff were "scared" of others and so might "...cross the line…" in terms of expected practice. The minutes of the meeting said, "This will be addressed at the staff meeting next week." There was no indication in subsequent minutes that this had happened or how the registered manager was exploring staff morale issues. The operations manager agreed with us that this concern needed following up. We were concerned about whether there was bullying and intimidation between staff and therefore about the culture of the service.

These concerns represented a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People and their relatives were empowered to express their views, although they felt they did not always receive feedback about the action taken in response to their suggestions. A visitor to the home told us, "I had a questionnaire only the other day and there's a newsletter too." They felt there were opportunities to express their views and keep up to date about what was happening in the service. We found there were improvements in the frequency of meetings for people so they could express their views on a regular basis. One person told us, "There are residents' meetings, I've been to two."

However, they went on to explain, "I think the meetings are a bit of a waste of time, if they make notes I've never been given a copy of the minutes." They did not feel that staff always responded to and acted on their comments. We agreed that there was room to improve how people received feedback about the action taken in response to their ideas and suggestions. We could see from minutes of recent meetings, that some suggestions people made, such as for changes to the menu, were acted upon. The menus we reviewed confirmed some changes that had been made. Minutes of subsequent meetings did not show that people received feedback about their previous ideas for improvement. They did not show discussion about the action that they could expect or to agree a compromise if it was not practicable to implement their ideas.

We noted that the registered manager's action plan to improve the service, said that there would be a programme of residents and relatives meetings advertised well in advance. We found that there was no such forward planning and so people's relatives may not have time to make arrangements to attend, particularly if they were working. The registered manager addressed this during our inspection by issuing a programme and making it accessible on noticeboards and in people's rooms.

The registered manager was aware of their obligations to ensure they notified the Care Quality Commission (CQC) about events taking place within the service. They ensured they provided relevant detail in these notifications and responded promptly to CQC if we asked for additional information.

We received conflicting views about the presence and visibility of the registered manager around the home. Four people said that they were not sure who was in charge but could suggest who they thought it was. We noted that they were occasionally forgetful in their responses and that other people were clearer about management arrangements. Relatives and visitors to the home knew who the registered manager was and were confident that he was accessible to them.

We saw that the registered manager engaged in a friendly manner with visitors to the service and knew whom they had come to see. They referred to him by name. One relative told us, "[Registered manager] has an open door policy; he is available on Tuesday afternoons if you need to talk to him about anything specific." We also noted that comments about the manager on a reviewing website were positive and included that the management team were always available to discuss issues. Four of the most recent reviews of the service, including three submitted in October 2017 before our inspection visits, rated the management of the service as excellent.

Staff also told us that both the registered manager and deputy manager were accessible to them for advice and support. They told us that the deputy manager was in and out of different areas of the home on a regular basis and that they saw the registered manager at least once a day out "…walking the floor." Additionally, a visitor to the home told us about care for the person they visited. The visitor said, "They [staff] have been brilliant. [Person] was in a dreadful home before and I think that's an advantage because we can see how much better it is here. They have been so helpful."

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 registered persons did not always ensure that there was clear information about how people's consent to specific aspects of their care was obtained and how staff could provide information in the best way to support decision making. Curtailment of a person's right to move from communal areas into their own room was imposed without proper consideration of whether it was the least restrictive option to ensure their safety or represented an unauthorised deprivation of their liberty. Regulation 11(1) and (3)

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 not ensured risks associated with the control of infection were properly managed. Practices for sharing slings, including toileting slings, and a lack of clarity about cleaning those properly presented some risks that any outbreak of infection could not be properly controlled and contained. Risks to people's safety and welfare, including from falls, were not always properly assessed and for some people, there was no such assessment. Guidance for staff about managing and mitigating risks was sometimes absent or inconsistent.

Regulation 12(1), (2)(a), (b), and (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had not ensured systems for good governance and leadership were operating effectively. They were not effective in assessing, monitoring and improving the quality of service people received and in monitoring and mitigating risks to people's safety and welfare. Some records were not maintained as complete. Systems were not robustly evaluated to see whether they were effective in improving practice and sustaining those improvements. Regulation 17(1), (2) (a), (b), (c) and (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had not ensured that staff were properly supported through supervision, consistent with their own policies and procedures. Performance and development needs were not therefore robustly addressed. Staff did not always complete training promptly when it was required to ensure they remained competent to meet people's needs and in line with the provider's expectations. Regulation 18(2)(a)