Harbour Care (UK) Limited

Coral House

Inspection report

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Poole
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was unannounced on 1 and 2 March 2017.

The registered manager has been in post since August 2016 and was registered in November 2016. There had been three registered managers at the home over the last two years with the regional manager providing part time cover in between managers. 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.

Coral House is a care home for up to seven people with learning disabilities in Poole. The home comprises of two separate houses next door to each other. They have separate entrances but access to the other houses can be gained through a locked side gate. At the time of the inspection five people lived in Coral House 1 and two people lived in Coral House 2.

We inspected Coral House in December 2015 and identified five breaches in the regulations and other areas for improvement.

At this inspection we identified four repeated breaches and three new breaches of the regulations. We made adult safeguarding referrals to the local authority as a result of the concerns we identified during the inspection.

Any risks to people's safety were not consistently assessed and managed to minimise risks. People's needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to care for people. Action was not taken in response to risks or changes in people's needs such as contacting the health and social care professionals involved with people. People particularly at risk were those nutritionally at risk, and those with complex health, care and support needs. Some people's health care needs were not always met because the healthcare they needed was not arranged, followed up or delivered. These shortfalls were repeated breaches of the regulations.

People's medicines were not always safely managed or administered and this was a breach of the regulations. This was because some people did not have their creams applied and medicines as prescribed and staff did not have clear instructions when they needed to give some people 'as needed' medicines or topical creams. The advice of the pharmacist had not been sought for one person's covert medicines.

Some people needed their foods and fluids monitored because of their complex health needs and because they were prescribed dietary supplements. However, action was not taken when shortfalls in people's nutritional intake changed, they were not having their prescribed dietary supplements and/or there were gaps or inaccuracies in their monitoring and medication records. This was repeated breach of the regulations.

There had been a high turnover of staff since the last inspection. This meant people were not consistently supported by a staff team that had the competence and skills to do so. Staff had not received the training they needed to be able to meet people's needs. These shortfalls were a breach of the regulations.

Some areas of the houses and people's equipment were not kept clean and or were damaged and this increased the risks of the spread of infection.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Two of the people living at the home were unlawfully deprived of their liberty. The registered manager had not recognised the risk of deprivation and made applications for a deprivation when these were required. This was breach of the regulations.

Although there were some improvements in records there continued to be shortfalls in the records kept about people and the management of the home. These shortfalls were repeated breaches of the regulations.

The home was not well-led. This was because the governance at the home was not effective and there had not been any consistent effective management at the home to drive improvements. Relatives and health and social care professionals also raised concerns about the frequent change in managers, communication systems and staff turnover at the home.

People received care and support in a personalised way. Staff were caring and treated people with dignity and respect. People and staff had good relationships. People had access to the local community and had individual activities provided.

Staff recruitment practices were safe and relevant checks had been completed before staff worked with people.

The registered and regional manager took some actions during and following the inspection in response to shortfalls we identified.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take

action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

As part of our enforcement action and regulatory response to the repeated breach of regulation 9 person centred care, we issued a warning notice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

People were not kept safe at the home.

Risks to people were not managed to make sure they received the correct care and support they needed.

The management and administration of medicines was not consistently safe.

Some areas of the building and equipment were not kept clean.

Staff were recruited safely.

Is the service effective?

Inadequate

People's needs were not effectively met.

Some people's health care needs were not met to ensure that they kept well.

Some people were not referred to their multidisciplinary professional teams when needed.

People did not receive their dietary supplements as prescribed.

People were given a choice of food and could help themselves to food and drinks in one of the houses.

Is the service caring?

Good

The service was caring.

People and most relatives told us staff were caring.

Staff understood how to provide care in a dignified manner and respected people's right to privacy.

Family and friends were made welcome and continued to play a part in in their family member's care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive to people and their needs and needed to be improved.

People did not always receive the care they needed, their care plans were not always updated and did not include sufficient information about their care and support needs. This meant staff did not have up to date information about how to care for people.

People and relatives knew how to make a complaint but learning from complaints was not shared and consistently acted upon.

Is the service well-led?

Inadequate

The home was not well led.

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

People were consulted about the home during 'Your Voice' meetings.

Coral House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 1 and 2 March 2017 and was conducted by two inspectors on the first day and one inspector on the second day.

We met and spoke with five of the seven people who lived at Coral House and used Makaton (a type of sign language) with one person. Some of the people we met had complex ways of communicating and were not able to tell us their experiences of the service. We observed staff supporting people. We also spoke with the regional manager, registered manager, a team leader and four support workers.

We looked at four people's care and support records and records about how the service was managed. This included four staff recruitment records, staff rotas, agency staff profiles, audits, meeting minutes and quality assurance records.

The provider completed a Provider Information Return (PIR) in January 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at incidents that they had notified us about. We contacted commissioners and health and social care professionals who work with people using the service to obtain their views. We spoke with one person's relative prior to the inspection and following the inspection we received email feedback from four people's relatives.

Following the inspection, the registered manager sent us information about applications to deprive two people of their liberty, the internal compliance assessment and improvement plan, the training staff had received and the staff training plan.

Inadequate

Is the service safe?

Our findings

At the last inspection in December 2015 we found shortfalls in the prompt reporting allegations of abuse. We gave a requirement notice for the breach of Regulation 13. The regional manager wrote to us in March 2016 and told us they would take action to meet this regulation by 31 March 2016.

At this inspection the registered and regional manager had made some safeguarding alerts to the local authority as required. However, we identified serious concerns and shortfalls about the safety of three people and made safeguarding alerts to the local authority. This was because people had not received the care and treatment they needed and actions had not been taken in response to people's changing needs. The registered manager and staff had not recognised that people were at risk of harm and neglect and had not made appropriate referrals to the professionals involved and raised safeguarding alerts.

The shortfalls in the people's care and treatment that resulted in safeguarding referrals being made were a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were posters displayed in the communal areas and office in both houses about how people and staff could report any allegations of abuse. These were supported by pictures to make the information easier to understand. People were also given a copy of the information to keep in their bedrooms and in their care plans. All of the staff had received safeguarding training as part of their induction and ongoing training.

Two people told us they felt safe at Coral House and they knew they could talk to staff and report any concerns to them. Overall, relatives felt their family members were safe at the home. They had been kept informed of any safeguarding incidents that their family had been involved in.

At the last inspection in December 2015 there were shortfalls in fully assessing and managing risks for people. This related to the risk management and monitoring of people who had complex health conditions and those people and others who needed the risks relating to their food and fluid intake monitored and managed. We gave a requirement notice for the breach of Regulation 12. The regional manager wrote to us in March 2016 and told us they would take actions to be compliant with this regulation by 30 April 2016.

At this inspection although there were improvements in the risk management plans for some people, risks were not consistently identified or managed. For example, one person had a PICA which is the persistent craving and compulsive eating of non-food substances. They had no toilet roll in their bathroom but had liquid toiletries and boxes of latex gloves that were not stored securely. We were told by the registered manager there was a risk the person would eat the toilet roll as they had done this in the past when they were younger. The person's risk management plan identified that the person was at risk of ingesting chemicals and that these must be securely stored. However, the assessment and plan did not make any reference to liquid toiletries, toilet rolls or risks from ingesting latex gloves. The registered manager took action and re assessed the risks and management plan. This included that because the person was supported by two staff at all times they could have access to the items in their bathroom including toilet roll.

We have not been able to test or review the effectiveness or safety of this new risk management plan.

Another person had complex health conditions that required constant monitoring. Their risk management plan included they needed to have their temperature taken twice a day to make sure that it stayed within a specified safe range. The person's risk management plan included that if the person's temperature fell below the safe range they needed to encourage the person to warm up, have a hot drink, record what action they had taken and then retake the person's temperature. However, staff had not recorded what taken action they had taken when the person's temperature had fallen below the safe range and they had not re taken the person's temperature as directed in the risk management plan. This person also needed their oxygen saturations checked every day. The equipment had been sent for repair and had not been available for a number of weeks. This meant staff had not been able to monitor the person's oxygen saturations and take action if their oxygen saturations were low as described in the person's risk management plan. The person's relatives also raised concerns with us that the equipment was not available for weeks at a time and no alternative had been sought during this period.

The ongoing shortfalls in the risk management for people was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some shortfalls in the management of medicines. Two peoples' topical creams were not applied as prescribed. There were gaps in the administration of people's medicines, ear drops and topical creams. This meant we could not be confident people had their medicines as prescribed.

Overall, there were PRN as needed plans in place for people's medicines and topical creams. However, one person's topical moisturising cream stated use 'as directed' but did not include how often and where the cream should be used. The registered manager told us the cream was to be used as a moisturiser. The cream had only been applied five times in a three week period and the person's skin was visibly dry. Another person did not have a PRN plan in place for their topical creams.

One person's medicines were crushed and added to food and drinks. The decision to do this had been recorded as a best interests decision and health professionals and relatives had been consulted. However, the advice of a pharmacist had not been sought to make sure that the medicines were safe to be crushed and added to food and drinks.

Hand written entries on the MAR sheets were not countersigned by another member of staff to check it's accuracy in line with both the provider's policies and NICE guidance on managing medicines in care homes.

People's medicines were safely stored and equipment used in the administration of medicines was cleaned after each use.

One person told us staff gave them their medicines when they needed them. Relatives told us as far as they were aware their family members received their medicines as prescribed.

Relatives told us that the high turnover and use of agency staff was of concern to them. This was of particular concern for those relatives of people with complex health and or complex communication needs. They fed back this was because agency staff or new staff were not able to 'recognise' or 'grasp' people's complex needs.

The registered manager confirmed there had been a high turnover of staff since the last inspection. The

team leader told us there were only five staff including themselves that had been working at Coral House at the last inspection. Some staff had been recruited that had already worked with one person at their previous placement and they predominately worked with the individual. The registered manager said they were managing to cover the staff shifts with bank staff and some agency staff.

This meant people were not consistently supported by a staff team that had the competence and skills to do so. For example, there were bank and agency staff and the staff employed at Coral House had not received all the core training to make sure they could meet people's needs, in addition half the staff team had not received basic life support training and nine of the twenty four staff had not received training in using one person's CPAP machine. This included seven of the nine staff who worked nights, when the person mainly used their CPAP machine, who had not received this training.

Relatives had mixed views as to whether staff had the skills and knowledge to meet their family members' needs. One relative fed back, 'The best of the staff recognise when [person] is unwell but I am not confident this is the case for all staff.' Another relative told us not all staff had the training and skills in working with people with autism and this had an impact on their family member.

The shortfalls in medicines administration and management and the staff's skills and competence were new breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The lounge in Coral House 2 was not clean and there were crumbs and a half eaten apple under the sofa. One person's bedroom wall had a patch of uneven, porous and damaged plaster where a medicine cabinet had been removed. This meant the wall could not easily be cleaned. There was an empty plant pot outside the patio doors at Coral House 2 that was full of cigarette ends and these had spilled out on to the patio. There were also cigarette ends in the one of the potted shrubs on the patio. None of the people who live at Coral House smoke. The registered manager emptied and cleared away the cigarette ends.

The two sofas at Coral House 2 were cracked, porous and damaged and this meant they could not be easily kept clean. The registered and regional manager took action and ordered new sofas during the inspection.

One person used an oxygen concentrator every night whilst they slept. The oxygen concentrator had a layer of dust on it and the filter was thick with dust. We asked the person when the filter was washed and they told us it was every Monday. We then asked staff and they said they thought it was every month. There were not any records to show when the filter had last been cleaned. This meant there was not any system in place for ensuring that the filter was cleaned weekly as recommended to make sure the person did not inhale dust and to keep the machine functioning properly. In addition, the staff handover record included that the person's bedroom had been deep cleaned two days before the inspection but the layers of dust in the bedroom would indicate that the room had not been deep cleaned.

Two professionals told us that during their visits to Coral House 1 there was sometimes a smell of urine. During the inspection there were not any unpleasant odours in Coral House 1.

The registered manager told us they had also identified that staff were signing the cleaning schedules but the tasks were not being consistently completed. This was supported by our findings.

The shortfalls in the prevention of and controlling the spread of infections and the shortfalls in the cleanliness of the premises and equipment were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives and staff told us there were enough staff to meet people's needs. The registered manager told us that staffing was calculated on people's individual needs and they ensured that where people were funded for one to one or two to one staffing this was provided. Each day staff were allocated to work with specific people. During the inspection staff supported one person on a one to one basis as described in their care plan. However, where people were funded by commissioners to receive set hours of one to one staff support this was not recorded as required in people's records as required by the funding authorities . One person's social worker also told us they had requested for one person's one to one support hours to be recorded but this had not happened.

Recruitment practices were safe and the relevant checks had been completed before staff worked unsupervised at the home. These checks included the use of application forms, an interview, reference checks and criminal record checks. In addition all new applications included an on line personality test to ensure new staff had the personal attributes to work with people with learning disabilities and complex needs. This made sure that people were protected as far as possible from staff who were known to be unsuitable.

There were personalised emergency fire evacuation plans in place for people. There were other emergency procedures in place for people, staff and the building maintenance. In addition, there were weekly maintenance checks of the fire system and water temperatures. There were systems in place for the maintenance of the building and equipment. A member of staff was employed to keep up with general maintenance and repairs across the provider's homes in the local area.

Inadequate

Is the service effective?

Our findings

There were mixed views from relatives as to whether they were kept informed about important events in their family member's lives where appropriate. Two relatives told us they were kept informed. However, one relative told us they were not kept informed when their family member was unwell and the staff at the home had not let them know until after the GP had visited. Another relative told us they were not told about their family member's GP appointments and changes to key workers so they knew who to contact for information.

At the last inspection in December 2015 we identified there was not an accurate health record that was accessible to people and included all of their health records.

At this inspection people had a separate health folder that included all contacts and visits with health and social care professionals. People had also health care plans to make sure staff understood what support people needed to maintain their physical health and mental well-being. However, some people did not receive the support to access appropriate health care and other health and social care professionals support as they needed it.

One person's plan identified that they had been supported to access a variety of health care professionals including their GP, dentist, chiropodist and district nurse. Records showed that this person's family members had been updated when the individual had received some form of medical support. This person had required support because of a specific problem and staff had sought GP advice. However, further support from the person's multidisciplinary team had not been sought promptly. This meant there was an extended period of time where the person was experiencing significant disturbances to their sleep. The person's tiredness and its negative impact on their physical and mental well-being had not prompted staff to involve health and social care professionals known to the person quickly, and this may have contributed to the worsening sleep pattern the person experienced. This person's health and social care professionals and relative raised concerns with us about the delays in contacting the multidisciplinary team for support.

Another person had seen the podiatrist in December 2016 and they had recommended the person had their feet creamed every day. This had also been identified at the podiatrist previous visit. This had not been included in the person's care plan and staff had not been applying the cream. The person also saw the dentist in July 2016 and they recommended the person have creams applied to their mouth and lips. This again had not been included in the person's care plan and staff had not been applying the cream. Thirdly, the person had seen the District Nurse in October 2016 and they had requested further information from the staff at the home. This had not been followed up and staff were not keeping records to be able to provide this information. Lastly, the person was seen by the GP and treatment was prescribed for a medical condition. However, this was not administered as prescribed and the person was not taken back to the GP until 14 days later for the same and another condition. This person's relative identified that this person had also missed some appointments with their specialist consultants and also some routine health appointments. On the second day of inspection the registered manager told us they had updated the person's care plan to include the recommendations of the dentist and podiatrist.

A third person's relative told us their family member raised a medical concern whilst they were at their day service. The staff at the day service contacted Coral House by phone and by recording in the person's communication book. However, no action was taken and the person did not see the GP until after the person's relative visited the home approximately two weeks later and they asked what had happened.

A fourth person had recently had their medicines reviewed with their GP and staff had been proactive about this. However, they had been seen by the dental hygienist in March 2016 and the health record included that the person needed to see a dentist. No action had been taken and the person had not seen the dentist nor was there any appointment booked. The person had been seen by the district nurse in January 2017 in relation to their hand being contracted and sore. The district nurse had advised staff to refer the person to an occupational therapist for a specialist hand splint. The records included that staff had made a referral to an occupational therapist in January 2017 but staff had not followed up the referral to establish what was happening.

These shortfalls in ensuring the care and treatment people received met their needs were a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in December 2015 we found shortfalls in the record keeping and monitoring of people's nutrition and hydration. We gave a requirement notice for the breach of Regulation 14. The regional manager wrote to us in March 2016 and told us they would take action to be compliant with this regulation by 31 March 2016.

One person had complex needs and was supported by a multidisciplinary professional team including a learning disability nurse and community dietician. The person's eating habits had changed significantly with them only having eaten four hot meals in the last month and this was whilst they were out in the community. Their food and fluid records showed the person had only been eating between three and six biscuits or snack bars a day. The records also showed the person had not routinely been having their prescribed nutritional supplement drinks. These had been signed as administered twice a day on the person's MAR sheets but the food and fluid records showed they had not routinely been drinking them. In addition they had not been weighed since the end of January 2017. This was because the person was reluctant to leave the home. The person had very clear support plans in place in relation to their nutrition and hydration but these had not been followed due to a change in the person's willingness to leave the home. No action had been taken in response to the person's change in behaviour, reduction in food intake and their prescribed nutritional supplements.

The community dietician who was involved with this person told us they had an arrangement with the registered manager and staff team that they were to contact them if there were any changes with the person's diet and to let them know each month what the person's weight was. This was so they could monitor the person's weight and offer advice and support the person with their nutritional intake if there were any changes. However, the dietician or the learning disability nurse had not been contacted following the change in the person's nutritional intake or to let them know that the person was refusing to be weighed. The dietician confirmed that alternative calculations should have been considered to monitor and asses how much weight the person had lost. However, no alternative ways of calculating the person's potential weight loss had been considered. The dietician contacted us two weeks following the inspection to raise further concerns that they had not been contacted by staff at the home despite repeatedly leaving messages.

Another person had a complex health condition that meant the amount of fluids they needed had to be closely regulated and monitored to ensure their sodium levels remained in a safe range. During the

inspection the person was in hospital because their sodium levels were unstable and could not be regulated. We reviewed the person's care plans and records because we had identified shortfalls at the last inspection. The person's plan required them to have a maximum of 300mls of fluid at any one time with a gap of 30 minutes in between. The fluid records prompted staff give the person set amounts of fluids every hour but did not include any flexibility to record smaller or larger amounts of fluid up to 300mls or at different times. For the fourteen day period reviewed there were seven gaps in the records at 6 and 7 pm and on five occasions staff had recorded they had given the person their set amount of fluids whilst their other records showed the person had been asleep. The registered manager acknowledged that as the person slept for such short amounts of time in any 24 hour period it was very unlikely that staff would wake the person to give them a drink. This meant the records were inaccurate and did not accurately reflect the fluids the person had drunk.

The shortfalls in ensuring people received dietary supplements as prescribed by health professionals and their nutritional and hydration needs were met were a repeated breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were involved where appropriate in the preparation of their food. People were involved in planning the menu and assisting staff with the food shopping. People were given choices as to what they wanted to eat throughout the day. Some people helped themselves to food and drinks from the kitchen in one of the houses.

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. Throughout the inspection we saw people freely moved around the home, doing what they wanted to. Staff sought people's permission before they helped them and checked with people each time what help or support they wanted and acted on what people said. One person's care plan explained how staff could provide them with options to make day to day decisions. We saw staff provided the person with options for their lunch and the person chose what they wanted including what they wanted to drink. We asked staff how they ensured people were supported to make their own decisions and they told us about how they achieved this including saying, "I would ask them", and telling us about how they might phrase questions differently to encourage people's decision making.

One person lacked mental capacity to take particular decisions and MCA assessments and best interests decision meeting records were available in areas including medicines, personal care and sharing confidential information. Staff had also contributed to best interest decisions made by other professionals such as for dental treatment.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had not received training about their responsibility to recognise the risk of deprivation and make applications for a deprivation when these were required.

Two of the people living at the home were unlawfully deprived of their liberty. In one person's case the registered manager had not understood their responsibility to make an application. Another person's DoLS authorisation had expired in January 2017. They were still deprived of their liberty but a further application had not been made. Following the inspection the registered manager sent confirmation that they made an application to the relevant authorising body for the two people.

People being deprived of their liberty without lawful authority was a new breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a mix of online electronic learning and face to face training for staff. There were core training subjects that staff were expected by the provider to complete and some specialist training to meet the needs of the people living at the home. There were significant gaps in the training provided to some staff. The registered manager sent us a training plan that identified all of the training that staff needed but this did not include any target dates. At the last inspection the regional manager had also provided us with a training plan that included the majority of the same training needed as was found at this inspection.

The registered manager had started to provide one to one support and supervision sessions for staff. However, these had only just started and staff had not received an annual appraisal or regular support and supervision sessions in line with the provider's policies.

The shortfalls in staff receiving appropriate support, training, professional development, supervision and appraisal was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Good

Is the service caring?

Our findings

People told us staff were caring and treated them with respect. They told us they liked all of the staff that worked with them. We saw good interactions between staff and people. Staff were kind and caring and communicated with people sensitively. We saw staff using a gentle approach with people, crouching so they were at the same height as people who were sitting down, and checking what people wanted or how they could help them. Observation showed staff knew people well and understood their preferred communication. One care worker was chatting with an individual who was smiling and cuddling the staff member. Their tone of voice and actions demonstrated a genuine warmth and regard for the person and their welfare.

Most relatives told us staff were caring and compassionate. One relative told us, "We have always felt that staff were kind and caring. [Person] seems very happy and positive about Coral House and staff." Another relative said, "[Named staff] is brilliant I generally ask her if I have a question or need help she is consistently helpful". However, when we asked another relative if staff were caring and compassionate they told us, "Some are, some less so".

One person used Makaton (a type of sign language) to communicate in addition to verbal and body language. They chatted with staff about a variety of things such as whether they wanted a cup of tea, and whether they were ok using verbal language and signs. We asked staff about this person and what they told us reflected the information in their care plan and what we saw.

People said that staff respected their privacy and dignity. They told us staff knocked before coming into their bedroom. Staff respected people's privacy, dignity and their decision making. This included balancing the people's needs for privacy whilst maintaining the high levels of support and constant supervision they needed, particularly those people who were supported by two staff at all times. Relatives told us their family member's privacy and dignity was respected.

People's independence was promoted and two people told us they were encouraged to participate in things around the home. People were involved in preparing their own lunches and helped themselves to food, snacks and drinks. There were mixed views from relatives as to whether staff promoted peoples' independence. One relative said their family member was supported to be independent within the parameters of their care plan. Two other relatives told us more could be done to encourage their family members' independence, with one raising a lack of structure in the person's day which limited their independence.

People kept in regular contact with their friends and families by phone and visits to Coral House. One person went to stay with their family for planned weekends and another person went out regularly with their family. Relatives told us they were free to visit and keep in contact with their family members. They said they were made welcome when they visited.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in December 2015 we found shortfalls in people's needs and preferences being fully planned for and care plans not being followed by staff. We gave a requirement notice for the breach of Regulation 9. The regional manager wrote to us in March 2016 and told us they would take action to meet this regulation by 31 May 2016.

Assessments were carried out and developed into a detailed person centred care plans. These provided staff with guidance on how the person wanted or needed to be supported in areas such as activities, personal care, healthcare, medicines and their preferred routines. One person's care plan described what was important to them and how they liked to spend their time. The information accurately described the person's likes, preferences and situations that made them anxious or worried. Observations of the activities the person was doing during the inspection and our discussions with staff reflected this information. However, there were some areas for people that were not planned for. For example, one person's plan did not include how they used the toilet in a very specific way and how staff were to support them. For another person the recommendations from other health professionals had not been transferred into a care plan and staff had then not delivered the care and support required. The registered manager took immediate action and updated peoples' plans with this information.

People were not involved in developing, writing or agreeing to their care plans where appropriate. For example, one person had signed to give their consent to having a flu jab but had not signed to agree to their care plans. Staff told us this person could become frustrated when staff recorded information about them but they were still not involving them in their daily recording.

There was not a consistent system in place for reviewing people's care and support needs and plans. Some people had a monthly key worker review but others did not. The monthly key worker reviews did not consistently include the person and did not identify or recognise significant changes in people's needs or where they had not received appropriate health or social care support.

Changes in peoples' needs were not consistently reviewed or identified and appropriate action was not taken in response to any changes. These shortfalls were a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person had moved into the home since the last inspection. There had been a positive transition plan implemented for the person who had complex needs. This had included staff visiting the person at their previous placement, specific staff being recruited that had previously worked with the person and a slow introduction and visits to Coral House before they moved in. Each visit was recorded and evaluated to see how it had gone for the person.

An activities coordinator had been recruited and a music therapist visited the home. A separate sensory and activity room had been built in the garden. This could be accessed from either Coral house 1 or Coral House 2. One person used the activity room during the inspection to do some art and another person from another

home also accessed the room to use the sensory equipment.

The provider had made some computer tablets available for people at the home to use. The registered manager told us they anticipated people using these more over the next few months to record their experiences.

One person had one to one support from staff during the inspection and they chose to spend this time having their nails painted by the staff member. They then painted the staff's nails and visibly enjoyed doing this.

People had a weekly plan of activities that was based on their personal preferences. This included activities in the home and in the community for most people. Some people attended day services. Some people were choosing not to access the community on a regular basis.

There was a written and pictorial complaints procedure displayed and each person's communication plan included details as to how they would let staff know if they were unhappy or worried.

We reviewed the complaints investigated by the registered manager. They were comprehensive and transparent investigations with actions identified to minimise the risk of reoccurrence. However, the learning from complaints was not shared with staff and actions were not consistently followed through. This was an area for improvement.

People and relatives knew how to raise concerns and complaints. One relative told us they had needed to raise concerns with the home because their family member was not shaved and needed their hair cut. Another relative fed back there had been a delay in the regional manager responding to a concern they had raised.

Inadequate

Is the service well-led?

Our findings

The home was not well-led. This was because the governance at the home was not effective and there had not been any consistent effective management at the home to drive improvements. There had been three registered managers at the home over the last two years with the regional manager providing part time cover in between managers. Following the inspection the registered manager contacted us to inform us they had resigned.

The provider's internal compliance teams had identified multiple shortfalls at the home over the months and weeks prior to the inspection. The actions identified during these audits had not all been completed. The quality assurance and monitoring systems undertaken by the registered manager and senior staff within the home were not effective as they had not identified the shortfalls found during the inspection and the risks to people.

The registered manager said they had been well supported by the regional manager and other registered managers in the local area. They said they were receiving training from the provider in leadership and the provider's management ethos and systems. However, the registered manager had been in post since August 2016 and stated this training would have been more beneficial if it had been provided when they were first appointed. The regional manager told us additional support had been provided to the registered manager by more experienced registered managers locally. They said one of the provider's business managers would be supporting the registered manager five days a week from the week following the inspection. This was in response to the provider identifying ongoing shortfalls at the home.

The provider's internal compliance visit in February 2017 identified the majority of shortfalls we found at this inspection. A small number of actions had been taken by the registered manager in response to the visit but those shortfalls that related to the immediate risks to people's health, care and welfare had not all been prioritised and completed. For example, for the person who was not eating properly, it was identified that there should be a weekly review and this be shared with all the professionals involved. As identified earlier in the report this had not happened and because of the serious concerns about this person's health and welfare we made a safeguarding alert to the local authority.

Feedback had been sought from people who used the service but this had not extended to people's relatives, including those who acted on people's behalf and professionals involved with the home.

There were mixed views from health and social care professionals in relation to how well-led the home was. Some professionals fed back the registered manager and senior staff were responsive and proactive. However, others told us that actions agreed at people's reviews were not consistently completed or followed up.

Relatives told us the registered manager listened to them and they could approach them with anything. Some relatives said actions that had been agreed with the registered manager were not always followed through. For example, one person had agreed that staff could phone their parent once a week to provide

them with an update on how they had been but this had not happened. However, they all raised concerns about the high turnover of managers at the home and the impact that this had on the quality and safety of the service for their family members and the subsequent staff turnover.

Health and social care professionals and people's relatives told us that the communication between the home and themselves needed to improve. One person's relative raised concerns about the communication between the home and their family member's school. Other parents and professionals identified that telephone calls or emails were not consistently responded to.

Medication audits were completed on a monthly basis. However, the shortfalls identified were not acted on. For example, medicines errors and omissions were not followed up with the staff involved. Staff medicine competencies had not been reviewed and reassessed in line with the provider's medication policies and procedures.

A comprehensive care plan audit that had been completed recently detailing what actions needed to be undertaken to ensure staff had accurate and up to date guidance. However, this was not consistently followed up or acted upon. Some people's keyworkers had undertaken monthly reviews of people's care and support. These were not effective as they did not identify the shortfalls found during the inspection.

These shortfalls in the governance, management and mitigation of risks, and the lack of effective improvement planning were a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in December 2015 we found the records kept about people were inaccurate, had omissions, did not record information required about people's health condition and did not reflect all of the care and support that had been provided to people. This meant there was not an accurate and contemporaneous record for each person. We gave a requirement notice for this breach of Regulation 17. The regional manager wrote to us in March 2016 and told us they would take action to be compliant with this regulation by 15 June 2016.

At this inspection we found some improvements in some people's record keeping. For example one person's foods and fluid records were detailed and reflected what they had either refused or eaten and drank. However, there were still shortfalls in other people's care records and other records relating to the management of the home. For example, one person's daily notes did not record whether staff had supported them in the way they needed in terms of their evening routine and one to one time with staff. Some people's and the home management records were not dated, handover records were incomplete and inaccurate, there were inaccuracies in another person's fluid monitoring records and cleaning records were inaccurate.

This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had regular 'Your Voice' house meetings. We saw where people had identified any actions these had been followed up. This was an improvement from the last inspection.

A staff meeting had been held by two other registered managers in January 2017. We saw from the minutes that actions identified for the registered manager to follow up had been completed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were deprived of their liberty without lawful authority

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There were shortfalls in the prevention of and controlling the spread of infections and in the cleanliness of the premises and equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were shortfalls in staff receiving appropriate support, training, professional development, supervision and appraisal.

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 9 HSCA RA Regulations 2014 Person-centred care There were shortfalls in the care and treatment people received.

The enforcement action we took:

We issued a warning notice