Platinum Care (Devon) Ltd

Hyne Town House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hyne Town House is a residential care home registered to provide accommodation and personal care for up to 45 people. The main three-storey building had 36 bedrooms, three of which could accommodate two people. At the time of inspection, the service was providing accommodation with personal care for 34 people, although two had been admitted to hospital so were not resident at the time of inspection.
There were also three self-contained units on the site which could accommodate six people. At the time of inspection, these units were either vacant or were providing accommodation without personal care to people who required assisted living. We therefore did not inspect these units.

People's experience of using this service and what we found
There were insufficient staff to ensure that people were supported to lead as independent lives as possible while remaining safe. There were some occasions when the lack of staff meant people did not receive the personal care they needed in a timely way. Staff were not given clear guidance and instruction about how they should ensure people who needed closer observation were kept safe. Staffing levels were insufficient to ensure people were supported to do regular meaningful activities whether in communal areas or in their own room. Staff were generally caring and compassionate when delivering care to people. However, the use of room numbers rather than people's names when staff referred to a person meant people were 'depersonalised'. Some staff used inappropriate language when discussing people who at times displayed behaviour that could challenge others.

There was a registered manager and senior staff from the provider organisation, who understood their responsibilities, including their duty of candour. However, some aspects of quality assurance and governance did not fully ensure the quality and safety of the service. This included the safety of air mattresses and water temperatures.

Staff were recruited safely and underwent training when they started. Training was updated regularly which helped to ensure staff remained aware of current best practice.
The home was clean and generally well-maintained. However, although audits and checks on hot water taps and air mattresses had been undertaken, actions had not been taken when issues were identified to ensure people were kept safe. There were insufficient clinical waste bins.

Medicines were administered safely. However, temperatures for medicines which required refrigeration had been recorded at unacceptable levels without action being taken to address this.

People and their loved ones, as well as visiting professionals, were generally complimentary about the service.

There were systems, which people and their families knew about, to raise concerns. Where concerns were raised, action was taken by the registered manager to resolve the problem. The registered manager and

senior staff reviewed incidents and accidents. They used this information to improve the service and reduce the risk of a reoccurrence.

People were supported to have choice. Staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.
People were assessed when they first came to Hyne Town House and care plans were developed to support their ongoing care. However, the care provided did not always reflect the information in the care plan.

People were supported to have a healthy diet they enjoyed and remain hydrated. However, some people were not supported to eat in a comfortable and suitable place, such as at a dining table.
The service supported people to make their own decisions as far as possible and within the requirements of the Mental Capacity Act 2005. Staff supported some people to remain as independent as possible. For example. by carrying out daily tasks and activities independently. However, there were some occasions where people were not encouraged to have a choice.

People's communication needs were understood, and people were supported to maintain their health, Staff contacted and took advice from health professionals when needed. People and their families had been involved in developing their care plan and reviewing it from time to time. Care plans reflected people's cultural, social and personal preferences. Families and friends were encouraged to visit and made welcome by staff. People were supported to have a peaceful and dignified end of life.

After the inspection, the registered manager sent details of actions they had taken to address the concerns. This included changes to staffing and work practices as well as addressing environmental risks.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 15 August 2018).

Follow up
The service remains rated requires improvement.

At this inspection we have made recommendations about the provider considering best practice guidance in support of older people mealtimes and supporting people with dementia. We also recommended the provider consider best practice on record keeping and reviews the guidance on ratings display.

We have identified four breaches in relation to the management and governance of the service, ensuring person centred care, the safe care and treatment of people and staffing levels.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hyne Town House on our website at www.cqc.org.uk.

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Hyne Town House

Detailed findings

Background to this inspection

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

Inspection team
The first two days of inspection, 15 August and 21 August 2019, were carried out by one inspector. On the third day, 3 September 2019, an assistant inspector helped carry out the inspection with the lead inspector.

Service and service type
Hyne Town House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included statutory notifications which the provider had sent to use about incidents at the service involving serious injury, deaths (both expected and unexpected) and allegations of abuse.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection-
We spoke with 14 people who used the service and nine relatives and friends about their experience of the care provided. We spoke with 18 members of staff including the registered manager, their deputy, the provider's operations manager, an administrator, senior care workers, care workers, agency workers, catering and housekeeping staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also met and spoke with five health and social care professionals, all of whom visited the service regularly. We reviewed four care plans and medicine administration records for four people. We also looked at four staff records, records of staff supervisions, audit and other records associated with the running of the service.

After the inspection –
We spoke by phone with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requiring improvement as there was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured all reasonable and practicable measures were in place to mitigate risks. We made a recommendation about the deployment of staff within communal areas to ensure people's needs were monitored and met in a timely way.

At this inspection this key question had deteriorated to Inadequate This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● At the last inspection, the lack of staff deployment in communal areas had been identified as a risk. This risk remained as there were periods of time when no staff were available to support people in communal areas for extended periods. Staffing levels were insufficient to meet the needs of the people being supported throughout the day. The registered manager said there were six care staff on duty during morning shifts and five in the afternoon. In addition, there were housekeeping and kitchen staff as well as the registered manager, their deputy and an administrator. Rotas confirmed this. 17 people required the support of two staff for personal care. Five people were cared for in bed. There were prolonged periods of time *up to ½ hour) on all three inspection days when there were no staff in the communal areas such as the lounges and conservatory. This meant people were being left unattended and with no social engagement for long periods of time. Staff also said they found it difficult to ensure people who spent most of their time in their bedroom did not become socially isolated.●One person spilled a cup of tea in their lap while sitting in the lounge. Staff were aware of the incident shortly after it happened and cleaned the spillage on the floor. However, the person waited for over half an hour before two staff were able to support the person to change clothing.

● There were mixed views from visitors on whether there was sufficient staffing to support people in a timely manner. Two visitors described how their loved ones had had to wait for an extended period on some occasions when they needed personal care. One relative said "It has happened more than once, staff come to see what [person] wants but has to find another member of staff to help. That can take some time, particularly at mealtimes." Another visitor described a similar situation, where the length of time before two staff attended the person meant they did not manage to get to the toilet in time.

● It was not clear how staffing levels had been assessed to ensure people were supported in a safe and timely manner. The registered manager said they did not use a dependency tool to determine the staffing levels needed.

There were insufficient staff to support people safely and in a timely way which is a breach of regulation 18 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014

●Other visitors, including relatives and professionals said they did not have any concerns about staffing.

● After the inspection, the nominated individual said they had increased the staffing levels by an additional staff member during the daytime shift.
● The service had policies and procedures to ensure staff were safely recruited. Staff files showed that appropriate records including checks from the disclosure and barring service (DBS) and references were in place.

Assessing risk, safety monitoring and management
● Some aspects of the environment and equipment were not safe and well maintained. For example, an audit undertaken in July 2019 had identified some hot taps where water temperatures were above 43 degrees. The registered manager said no action had been taken to address the findings of the July audit. During the inspection, a shower and a bath tap both registered temperatures above 43 degrees. This put people at risk of being scalded. The registered manager took immediate action to ensure the two bathrooms were locked. By the final day of inspection, the water temperatures in both facilities were below 43 degrees.
● At the last inspection we found people were at risk of developing pressure damage to their skin as pressure mattresses were set at the wrong level for the person's weight. At this inspection, we found this was still a risk. Although there were records of mattress settings, there was no evidence of action being taken when there was a change in the setting which did not correlate to a weight change.
● Environmental risks to people had not always been fully assessed and action taken to address the concerns. For example, there was a poorly lit staircase off a quiet corridor with a locked door at the top. This posed a risk particularly to people living with dementia. The registered manager said they had plans to get the downstairs doors locked to prevent people using the staircase. They also said staff were aware of where everyone in the home was and therefore the risks were mitigated. However, we observed people moving around the corridors with no staff present to monitor their whereabouts. After the inspection, the provider informed us they had added locks to prevent people accessing the staircase.
● Care plans included some information about people's physical and mental health. However, the information was not always correct or sufficiently detailed and so did not always provide clear guidance for staff. For example, one care record had conflicting information regarding the person's diet, which meant they was at greater risk of being given inappropriately prepared food.
● One person's care plan stated staff should be aware of their whereabouts due to a recent unexpected seizure. The care plan contained good detail about what signs to look for and what action staff should take. However, nothing had been put in place to enable staff to be aware of the persons whereabouts. One member of staff said they were not aware of the person requiring regular checks, and that it was 'just luck' if staff knew where the person was.

Using medicines safely
● At the last inspection, we recommended improvements to the medicine management systems. This included recording medicines storage temperatures and recording of covert medicine administration.
● At this inspection, although refrigerators which stored medicines had maximum temperatures recorded, these were, on occasions, at room temperature which was above the recommended temperature. We discussed this with the registered manager who said she would investigate this and take the action necessary to monitor temperatures for refrigerated medicines. After the inspection, the provider informed us they had bought new thermometers to enable accurate recordings of medicine refrigerator temperatures."

The environment and equipment used in the service was not safe which is a breach of regulation 12 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014

● The service was now ensuring that where medicines were administered covertly, this had been agreed and documented with the person's GP as in their best interests.
● Medicines stored in trolleys were kept tidy and secure.
● A medicine round took place during a lunch period. This meant people were being offered medicines as they ate their meals, which was an intrusion. The registered manager said they would look at ways to alter the timing of the medicines round so that people did not have to take medicine while eating their meal.
● Staff had been trained and understood how to administer medicines. Staff were caring and took time to talk to people about their medicines. For example, a member of staff explained about the medicine a person was being offered so they were able to understand why they were taking it.

Systems and processes to safeguard people from the risk of abuse
● People said they felt safe. Relatives also said they had no concerns about their family member's safety. Comments included "No concerns whatever."; "Very good, very safe."
● Staff had been trained in how to safeguard vulnerable people from the risk of abuse. Staff were able to describe the actions they would take if they thought abuse may have occurred. This included reporting it to senior staff.
● The registered manager understood their responsibilities to report and investigate any safeguarding concerns.

Preventing and controlling infection
● The service did not have enough equipment to safely manage clinical waste. There was only one receptacle for clinical waste bags which was located in a downstairs toilet. In other areas of the service, clinical waste bags were placed on the floor and on a bathroom hoist. This posed a greater risk of spreading infection. Staff said they had been requesting clinical waste bins for several months. During the inspection the registered manager confirmed that clinical waste disposal bins had been ordered.
● The home was clean and hygienic in other respects.
● Staff understood the importance of good infection control processes. Staff used personal protective equipment such as disposable gloves and aprons appropriately.

Learning lessons when things go wrong
● Staff understood their responsibility to record incidents and accidents which were reported to the registered manager. For example, any falls that occurred were reported and investigated to see if there were actions which could reduce further occurrences.
● The registered manager and other senior staff from the provider organisation reviewed and analysed incidents and accidents to see if there were themes or patterns. This supported learning to reduce the risks of a reoccurrence.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
- A pre-admission assessment was undertaken to ensure care was planned and reflected people's individual needs and preferences.
- One person's physical health care plan stated' 'carers will encourage [person] to be as independent as possible, prompting her to maintain upper body strength by engaging in activities such as ball throwing'. However, there was no record of this person being assisted out of bed in the previous 14 days. There was no information in the person's care record which would indicate the person had been unwell and therefore confined to bed.
- Care plans included information about how people liked their care to be delivered. Information in people's care plans was person-centred and provided a good insight into people's history, background and what was important to them. This helped staff understand how to support each person appropriately. For example, a care plan described how the person loved music and singing. Staff described how they would often sing with the person when doing personal care.
- Since the last inspection, the provider had introduced an electronic care planning system. Staff said this meant they were aware of what support a person had received more quickly than the using previous paper systems. Some of the devices for inputting information about people's care were on walls in corridors. The registered manager said this meant staff could record information immediately after they had completed a task. However, when we stood beside a member of staff completing an entry on the device we were able to see the record clearly. This meant that people's information could be visible to visitors and therefore compromise a person's right to confidentiality and privacy.

We recommend the provider consider best practice guidance about the use of electronic care records.

Supporting people to eat and drink enough to maintain a balanced diet;
- Meals were served to people in two dining rooms, in people's bedroom or in a lounge. However, some people who ate in the lounge were not provided a suitable table to eat from. At mealtimes, some people were hunched over a low table which meant they had poor posture and an increased risk of spilling food on themselves. One person said they preferred to use a coffee table, but there was no evidence in care records this was the preference for other people.
- Tables in the downstairs dining area were laid with white wipe-clean tablecloths and some meals were served on white crockery. This did not conform to best practice for people with dementia. There were flowers on the table and a menu for the day's meals.
- People were supported to remain hydrated as staff offered drinks to people during the day.

We recommend the service investigates best practice in respect of supporting older people at mealtimes

● Meals were freshly prepared by staff who understood different dietary requirements such as people who required food to be prepared such that it reduced the risk of choking.
● People's nutritional needs were catered for and they were given a choice of what they wanted to eat. Meals appeared to be tasty and well cooked. People said they enjoyed the food. Comments included "The food is really good" and "I really enjoy the food, particularly the fish and chips."

Adapting service, design, decoration to meet people's needs
● Hyne Town House is a Georgian group of buildings which have been adapted to support older people, including those living with dementia. As well as a main two storey house, other buildings provided accommodation for older people who do not require personal care. We did not inspect these as they are not regulated services. The main building was three storeys. Upper storeys were accessed via a lift or staircase. The service had adapted bathing facilities, including hoists and raised toilet seats. Externally there was a patio area and garden which people could use. Bedrooms had been decorated and personalised with people's furniture and ornaments.
● Some adaptations had been carried out to support people living with dementia. For example, 3-d box frames with memorabilia such as old bank notes were on display. However, these were positioned at a height on corridor walls which made it difficult for some shorter people to spend time looking at them. In a corner of the downstairs lounge there was an old record player and other items to encourage people to remember their past. There were also dementia friendly clocks, fiddle mitts and two empathy dolls. However, the service was not completely dementia friendly. For example, signage did not support people with dementia to maintain independence. We recommend the service investigates best practice in respect of supporting people with dementia

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to see their GP and other health professionals when necessary.
● Health professionals said staff were good at contacting them appropriately. They commented staff were knowledgeable and would follow their advice.
● People were also supported to access other health professionals including a chiropodist, optician and dentist
The registered manager and staff worked with other services to ensure people were supported to move between different services. For example, people on respite were supported to move back home. The provider worked with other agencies to ensure the person had the support they needed when they went home.

Staff support: induction, training, skills and experience
● Staff completed an induction when they were first employed. Staff updated training regularly to ensure they were kept up to date with current best practice.
● The provider had a training matrix that evidenced when staff had attended training and when their training was due.
●Staff were supervised regularly and had appraisals of their performance. Where staff had been on extended leave, such as maternity leave, they were offered 'keep in touch' days, which was good practice. Where staff had not been able to take up these opportunities, they were paired with another care worker during their initial shift. This helped them to meet new people and also update their knowledge about people's support and care.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff were knowledgeable about upholding people's rights and ensuring they were asked for their consent. If people said or showed they did not want support, staff were understanding and approached them later.
● DoLS applications had been made to the relevant local authority for all the people at Hyne Town House. One person's DoLS application had been authorised. The registered manager kept records of when applications had been made. They updated records when changes to an application were needed.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requiring improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; respecting equality and diversity

- Staff referred to people when talking to other staff as room numbers. This included staff talking to each other over walkie talkies. One person wearing glasses had a large label with their room number attached to an arm of the spectacles. This depersonalised people and was not respectful. The registered manager said referring to people using their room number was to ensure people's privacy. However, we discussed with the registered manager whether staff could talk about people to each other by referring to people's name without discussing personal details.
- The form used to record supervisions with staff posed the question "Do you find any residents difficult?" This does not show respect to people who may at times display behaviour that challenges others. Notes of a supervision carried out by the registered manager with a member of staff referred to people by their room number and described one as "can be stroppy." We discussed this with the registered manager who said they had written what the member of staff had said verbatim. However, when asked whether they had challenged the member of staff about their use of language, they said they had not. There was also no evidence that there had been any discussions with the member of staff about how they could support the person more effectively.
- People received personal care in the lounge from a visiting chiropodist. Although screens were put around the person and professional, both were still partially visible. The visit occurred during the lunch period and at one point the chiropodist used an electric device which made a noise. This drowned out the sound of the TV. This did not show respect for either the person receiving treatment or the other people in the lounge eating their lunch.
- Staff did not always consider how to support people to remain as independent as possible when eating. For example, one person sitting in the lounge was not asked if they would like to sit at a table. They were asked for their choice of a cereal but were not offered the opportunity to put the milk and sugar on, as these were already on the cereal when served. When we spoke with the person, they said they preferred to sit up at a nicely laid table and serve themselves. They also said they would have liked toast which was not offered to them.
- Families and friends were encouraged to visit whenever they wanted. Throughout the inspection, we saw visitors being welcomed into the home and offered refreshments. Staff clearly knew family and friends well and showed kindness and compassion to them as well as people living in the home.
- Staff were caring and compassionate when working with people. For example, one person liked to be 'busy'. Staff encouraged them to get involved in tasks around the home. Another person enjoyed playing

the piano, so staff ensured they were able to do this in the conservatory.

● People and their families were very positive about the care and support provided by the registered manager and staff. Comments included "Really good staff, always very helpful." A visitor commented "Staff are very caring, lovely. I have seen a person get distressed and staff have gone over and given them a hug and comforting words."

● The registered manager said people and their families were involved in reviewing their care plan. Relatives confirmed they were asked if they wanted to be involved in care plan reviews and meetings.

● Staff offered people choices about where they sat, what clothes they wanted to wear and what they ate. Staff were very familiar with people's preferences. For example, they described how they talked about dogs when supporting the person to eat. They said although the person was not aware of their surroundings due to their dementia, they would often respond very positively if they chatted about the breed of dog the person used to own.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requiring improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- There were mixed views from people, visitors and staff about there not being enough staff time to ensure people were encouraged to do activities of their choice either individually or in small groups. They also said there were not enough staff to support people when they chose to stay in their room.
- Most people were not supported to follow their interests and take part in activities they enjoyed. People mainly stayed in their bedrooms or sat in the large downstairs lounge and conservatory with very little meaningful occupation or social engagement. The large downstairs lounge had chairs pushed back against walls. This meant it was not easy for people to get involved in small group chats or activities.
- There was an activity board on display in the downstairs lounge, however, this did not reflect the activities which were offered during the inspection. This meant people would not be supported to plan their days to engage with activities. It also could be confusing for people living with dementia.
- On the first inspection day, there was music playing in a corridor adjacent to the lounge, a person playing piano in the conservatory on the far side of the lounge and the television was on. This meant that when sitting in the lounge there was noise from three sources. Most people in the lounge did not appear engaged with any of these and were not able to mobilise independently. One person said it was very noisy and they would prefer more peace and quiet, another said they were watching the TV but could not hear it very well. One person who was able to self-mobilize had sat near the piano and said they enjoyed the piano playing.
- People in the downstairs lounge were not offered a choice of drinking receptacles. For example, we observed everyone received a cup of tea in a plastic mug. While this can be helpful for some people living with dementia, one person said they did not like this, but was "what I'm given." They said, 'I would much prefer china.'
- We observed one staff member sitting down with a person to chat, however they were straight away asked to assist another staff member elsewhere and had to leave them.
- Care plans contained some detailed and person-centred information about how to meet people's needs, However, care plans were not always sufficiently detailed. For example, information about one person with a wound was incomplete. Another care plan contained very limited information about a person's hydration needs or what staff had done when the person had not drunk much during a day.
- Staff told us they didn't have time to read the care plans. They said this meant they were not always aware if changes to a person had occurred, particularly if the member of staff had been on leave.

People's care was not always personalised or delivered in a way to ensure they did not become socially isolates which is a breach of regulation 9 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014

● During the inspection, some group activities were run. For example, on one day, there was a visiting musician in the downstairs lounge. People and some visitors clearly enjoyed the session and joined in with singing. Staff helped people to dress up in hats which created a jolly atmosphere. On other occasions, staff were seen supporting people with one-to-one activities, for example a member of staff spent time using memory cards to help conversations about old times with a person. Another person received a manicure. However, staff said they rarely had time to spend any one-to-one time with people. They said the one-to-one activities during the inspection, were unusual. They said they normally did not have enough time to respond to people individually.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care plans contained details about people's sensory or hearing impairment and described their communication needs.
● Staff were aware of how to communicate with each person in such a way they were able to understand and be understood.
● Where necessary health professionals were involved to support people with communication, for example optometrists and audiologists.

Improving care quality in response to complaints or concerns
● There were systems in place for people to complain. Fliers around the home, described what people should do if they had a complaint. People and their families said they knew how to raise a concern or make a complaint. Most said they had not had reason to complain but felt their complaint would be listened to if they spoke with staff or the registered manager.
● One relative said they had written to the registered manager about the lack of meaningful activities for people. They said, "not big activities, just staff in the lounge and about to offer a chat or small activity." They said they had not yet received a response but felt this was reasonable as the letter had only been sent recently. After the inspection, the provider said they had responded in August 2019 by registered delivery. Another relative raised a concern by talking to the registered manager in the office. The registered manager provided assurances to the person who left satisfied with the outcome, saying "That's fine thanks."

End of life care and support
● People were provided caring and dignified support at the end of their lives. Staff showed high levels of compassion to people and their families throughout the final days of the person's life. We met relatives and friends who were visiting a loved one at the end of their life. All of them said staff had done everything they could to support the person to have a pain-free and peaceful passing. Comments included "Really lovely staff, who have given us space and privacy."; "Always able to visit and spend quiet time with [person]."; "Nothing too much problem."; "Obviously never quite like home, but nice room, with views to sea and church."
● Kitchen staff suggested and offered food which might tempt a person near the end of their life to eat, when their relative came to talk to them. This showed staff were supporting the person and their family to meet the person's needs.
● However, two care plans did not contain any details about people's wishes as they neared the end of their life. One plan stated, "Update needed if informed by GP, [person] is entering final stages of life." This meant that staff would not have the information about the person's, or their families wishes, if they became suddenly unwell.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requiring improvement as there was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured there were effective arrangements in place to monitor the quality and safety of the service. The provider had also not ensured that records had been maintained in respect of people using the service.

At this inspection this key question has remained the same as we found the provider was still in breach of regulation 17 (Good Governance). This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Following the previous inspection, the provider and the registered manager had taken some actions to improve quality assurance, for example compiling information about air mattresses and systems to monitor their air pressures. However, the systems to monitor the quality and safety of the service were not always effective. For example, although checks were carried out on water temperatures, actions had not been taken to address issues where the water temperature was found to be too high in July 2019. Checks were carried out each month on air mattress pressure; however, where settings varied from month to month without a change to the person's weight, no action had been taken to investigate why. This put people at risk.
- There was a clear management structure, with defined areas of responsibility and accountability. Senior staff from the provider organisation visited the service regularly to undertake assurance checks. However, these had not identified areas of concern found during this inspection. This included not identifying people were at risk of not receiving care in a timely way or having their social needs met due to staffing arrangements. Senior staff and the registered manager had also not taken timely action when safety issues were identified, for example hot water being above 43 degrees.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care;

- The majority of staff spoken with said they did not always feel supported by the registered manager and senior staff. For example, they said how they had raised issues which they felt had not been listened to or addressed. Staff described how they had raised concerns about staffing levels and some equipment at staff meetings, but no action had not been taken. We discussed this with the registered manager and a senior manager who said they did not recognise this as a problem as they believed that they responded to staff concerns appropriately. However, our evidence supports the concerns raised by staff, showing no actions had been taken.

● The majority of staff we spoke with were unhappy about how they were engaged and involved in developing and improving the service. Staff described how senior managers were remote and did not engage with the day to day care and running of the home. They said although the office was centrally placed, the registered manager and other senior staff did not come out of their office. The registered manager and senior staff said they did not recognise this criticism but would consider how they worked with staff in future.
● There were staff meetings and handovers where staff were able to discuss people and processes to support their learning and improvement to care. Staff said that although there were staff meetings, they did not feel their opinions and feedback was taken into account. We saw some evidence to support this, for example staff raising concerns about clinical waste receptacles which had not been responded to quickly.

The provider and registered manager had not ensured there were systems in place to monitor the safety and quality of the service which is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, the nominated individual sent details of the actions they had taken to elicit staff feedback. This included having meetings with staff and sending out a staff questionnaire.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider supported and promoted equality and inclusion within its workforce. For example, staff from overseas were supported to improve their language skills where English was not their first language. Some staff were also supported with temporary accommodation when they first moved to the UK from abroad.
● Staff were supported to spend time in the service during maternity leave. The service offered "keeping in touch" days to staff who had recently given birth. These days help these staff to remain aware of what is happening in their workplace if they chose to have maternity leave.
Working in partnership with others
● The registered manager and care staff worked in partnership with other professionals and agencies to ensure people received the care they needed. For example, staff worked closely with district nurses and palliative care nurses. A professional commented "Staff are knowledgeable…helpful and take on board advice."
● People and their relatives were generally happy about the leadership within the service. Comments included "Nothing too much problem."; "everything fine, any queries or concerns are sorted out immediately."; "The home is good and very supportive."
● A health professional commented "Management are always willing to talk if I have feedback."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager worked in an open and transparent way when incidents occurred at the service in line with their responsibilities under the duty of candour.
● The registered manager understood their legal responsibility to notify the Care Quality Commission (CQC) of events such as deaths, incidents and injuries. This is important because it means we are kept informed and can check whether the appropriate action had been taken in response to events. The registered manager had also ensured the rating from their latest inspection was on display within the service as required by CQC. However, the rating was not displayed in the area at the top of the web page, which meant people visiting the website needed to scroll down to see the rating.

We recommend the provider reviews the guidance on how to display the service's rating

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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of people was not always meeting their personal and social needs. Regulation 9 (1) (2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care plans did not provide sufficient information for staff to support people safely People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Equipment such as air mattresses were not at the correct pressure to ensure people were not at increased risk of pressure sores Medicines which required refrigeration were not stored at the correct temperature Regulation 12 (1) (2) (a) (b)(d)(e) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Some audits had not identified issues relating to the safety of equipment. Audits and checks had identified quality and safety issues which had not been addressed in a timely manner. There had been a failure to identify care plans did not contain the information necessary to support people safely. Systems were not in place to ensure the staffing

	levels were sufficient to meet people's needs Regulation 17 (1)(2) (a) (B)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to ensure people were supported safely and effectively Regulation 18 (1).