Bethesda Eventide Homes

Bethesda Eventide Homes - Ipswich

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bethesda Eventide Homes - Ipswich 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. This service does not provide nursing care. Bethesda Eventide Homes - Ipswich accommodates up to 26 people in one adapted building. There were 26 older people living in the service when we undertook this comprehensive unannounced inspection on 1 December 2017.

There was a registered manager in place. 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.

This service was rated as Good at our last inspection of 7 August 2014. During this inspection of 1 December 2017 we found that the service had not sustained the previous Good rating. The overall rating was now Requires Improvement. The key questions Safe, Effective, Caring Responsive and Well-led were rated Requires Improvement. We found breaches of Regulation 12: Safe care and treatment, Regulation 18; Staffing, Regulation 11: Need for consent, Regulation 14: Meeting nutritional and hydration needs and Regulation 17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed in people's care plans to identify how people were provided with person centred care which was tailored to meet their specific needs. There were inconsistencies in care records which needed attention to ensure that staff were provided with the most up to date guidance on how people's needs were met. In addition, people's care records which included guidance for staff about the risks in people's daily living and how these were not robust and detailed. The ways that the service assessed risks to people and actions taken to reduce the risks required improvement to provide people with safe care at all times. There was limited evidence in records to show that people had participated in the planning of their care.

Improvements were needed in the systems in place for the safe handling of medicines. This included how staff recorded when people had been provided the medicines that were prescribed for administration externally, such as creams.

The majority of staff were trained in safeguarding, however, some staff had not received this training and some had not received it since 2013 or 2014, which meant that they were not provided with the most up to date information about how to keep people safe from abuse.

Staff were not provided with sufficient training to meet people's needs effectively. Improvements were ongoing in how staff were provided with supervision.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

People were supported to see, when needed, health and social care professionals. The service worked with other professionals involved in people's care to improve people's lives. However, the records maintained were kept in a confusing way.

Where there were concerns about people's dietary intake referrals to other professionals were made. People were provided with high calorie supplements to assist people to maintain a healthy weight. However, the ways that people made their choices about meals needed improvement to provide a more person centred service.

Where incidents had occurred the service did not have robust systems in place to learn from these and use the learning to drive improvement in the service. The quality assurance systems in place which assisted the provider and the manager to identify shortfalls and address them were not robust.

There were some staff vacancies which were being covered by existing staff and agency staff. The service was actively recruiting to these vacant posts. Recruitment of staff was done safely and checks were undertaken on staff to ensure they were fit to care for the people using the service.

The environment was clean and hygienic and there were infection control systems in place.

Staff spoke about people in a caring and compassionate way. People had positive relationships with the staff who supported them.

People were provided with the opportunity to participate in activities that interested them.

People's views were listened to and acted upon relating to their end of life care. There were systems in place to support people to have a pain free and dignified death.

There was a complaints procedure in place, which needed updating, and a system to manage complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were needed in how people were provided with their medicines prescribed for external use, such as creams.

There were systems in place designed to minimise risks to people and to keep them safe from abuse. Staff training needed to be updated to provide staff with the most up to date information about how to keep people safe from abuse.

Improvements in staffing numbers were ongoing to ensure that there were enough staff to meet people's needs safely. The systems for the safe recruitment of staff were robust.

There were systems in place to reduce the risks of cross contamination.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not sufficiently trained to meet the needs of the people who used the service.

The service was not up to date with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. There was limited information in care records about people's capacity to make their own decisions.

The systems in place to provide people with their dietary needs and meals were not robust and person centred.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support. The service worked with other professionals to provide people with a consistent service.

There was an ongoing programme of decoration in the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Improvements were needed in how the service demonstrated that people's choices were respected and listened to.

People were treated with respect and their independence was promoted and respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed in how people's wellbeing and needs were planned for to ensure their individual needs were being met. There were plans in place to make these improvements but they had not yet been implemented.

People were provided with the opportunity to participate in meaningful activities.

There was a system in place to manage people's complaints.

There were systems in place to support people to have a pain free and dignified death.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The quality assurance systems in place which helped the provider and registered manager to independently identify shortfalls were not robust to provide people with a safe, effective, caring, responsive and well-led service at all times.

Bethesda Eventide Homes - Ipswich

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 comprehensive inspection took place on 1 December 2017 and was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at information we held about the service including the previous inspection report and notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public. We asked for feedback about the service from the local authority and the clinical commissioning group.

We spoke with six people who used the service, one relative, one visitor and a visiting health professional. We observed the interaction between people who used the service and the staff. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able to verbally communicate their experience of the service with us.

We looked at records in relation to four people's care. We spoke with six staff members including the senior team leader, team leader, care, and catering. We looked at records relating to the management of the service, three staff recruitment files, training, and systems for monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Safe was rated as Good at our last inspection of 7 August 2014. At this inspection of 1 December 2017 we found that Safe was now rated as Requires Improvement.

The ways that the service assessed risks to people and actions taken to reduce the risks required improvement to provide people with safe care at all times.

Care records included risk assessments, however these did not provide detailed information to guide staff about how these risks were minimised. For example, there was inconsistent information about the equipment people used to assist them with their mobility. One person's records referred to the use of a stand aid and elsewhere in their records there was reference that the person should be assisted using a hoist. Another person's records stated that they used equipment to assist them to walk, but they were reluctant to use this. There was no further guidance to staff about how the person mobilised in a safe way. In addition in other parts of their records it stated that the person was unsteady on their feet, had a series of falls, was getting better at using the equipment and preferred using a walking stick. There was no clear information about how to support these people safely because it was inconsistent throughout their records. It was particularly important to have up to date care records in place because the service were using agency staff to cover staff vacancies and these needed guidance about how to meet people's needs. Without this information there was a risk of people receiving unsafe care.

Where people had falls there was a system in place to refer them to the falls team to gain guidance on any actions the service could take to minimise these. However, records of falls were kept in a confusing way. They were all on loose records mixed in with incidents, accidents and professional visits records, they were not in any sort of order and there was no record to show how each incident had been reviewed and analysed to reduce further risks.

Where people had injuries such as bruising, pressure ulcers and or skin tears, these were written on a body chart. However, there was no cohesive way of completing these, for example several entries were on the same chart and these were not cross referenced to incident and accident forms or any treatment received or actions taken to mitigate risks. We were not assured that the system in place supported the registered manager and staff in learning from incidents and using this learning to drive improvement and reduce future risks.

Information was recorded in the staff communication book that included guidance for staff if any issues with people's wellbeing arose. For example, in November 2017 an entry stated that a person was at risk of falls and to ensure that staff stayed with them in the communal areas and had a mat out to advise staff if they attempted to stand alone. Staff were also reminded to take a person's pressure relief cushion if they moved to the communal areas. However, this had not been transferred to the care plans to give staff the most up to date guidance on how risks were reduced.

The minutes of a staff meeting in September 2017, showed that they had discussed falls and incidents and

how to reduce them in the future. Staff suggested ideas to reduce incidents, such as clutter in a person's bedroom. However again, none of this had been transferred to people's care records. The staff also discussed that there were gaps in medicines administration record (MAR) charts for creams and this needed to be addressed.

Improvements were required in the systems for the safe management of medicines. We reviewed the MAR charts for medicines for external application, including creams, such as barrier creams to assist in the reduction of risks for pressure areas. These MAR charts had significant gaps and were not completed to show that people had received these medicines in line with their prescription. This did not give reassurance that people were provided with these medicines as prescribed.

Where people were prescribed medicines to be taken as required (PRN), for example to reduce their pain, there were no protocols in place. These should provide guidance to staff at what point these medicines should be considered for administration to reduce inappropriate administration of these PRN medicines.

All of the above is a breach of Regulation 12; Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training in safeguarding had not been kept up to date. Records showed that the majority of staff were trained in safeguarding, however, some staff had not received this training and some had not received it since 2013 or 2014, which meant that they were not provided with the most up to date information about how to keep people safe from abuse. New staff were provided with safeguarding training but for existing staff this had not been updated. Staff did tell us about what action they needed to take if they suspected someone was being abused.

Despite the shortfalls we had found in relation to risks to people, they told us that they felt safe in the service. One person said, "Yes I am safe there is always someone on duty who will act in an emergency." Another person commented, "I am safe without a doubt, I trust the staff around me and can use my bell any time." One person's relative told us, "[Person] had [pressure] ulcers when [they] came here and they [staff] have cleared them up."

Equipment, including hoists, portable electrical appliances and fire safety equipment, had been serviced and checked so they were fit for purpose and safe to use. There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire. During our inspection the fire alarm was activated. We saw that staff were aware of the actions they should take, for example, gathering at a designated area to seek guidance from the lead fire officer of the day.

We saw that people wore alarm pendants around their neck to use to call staff if they required assistance. People told us that when they called for staff assistance the staff responded promptly. One person said, "Got a bell to ring, you ring it and they [staff] are there, they might be caught up in an emergency but they always come and check you are alright and say we have got an emergency and will be back." Another person commented, "I press the red button and the carers come and see what I want. They come fairly quickly almost always and if there is an emergency somewhere else might be a little longer. Staff are very good here, they come and tell me they will be back. Longest wait is five minutes and usually there is a good excuse."

During our inspection we saw that staff were available to meet people's needs and requests for assistance were attended to, including call bells.

We received mixed comments from people and relatives about if they felt that there were enough staff to

meet people's needs. People did speak about being short staffed and the use of agency staff. One person said, "I have a bell around my neck and [staff are] usually fairly quick, on occasion when agency staff on it makes a difference they are not as quick, regularly staff often sick and have to use agency." Another person commented, "Bit short of staff quite often, use agency and they are not used to the place, some good some not so good and would sooner they did not use people to stand in." Another person said, "They [staff] give me enough time, they are a bit rushed when they are short staffed." Another person told us, "They have had one or two hiccups with staff not turning up for work recently from sickness, but they pull together and help one another out. When they are fully staffed it runs well."

A health professional told us, "They [staff] work hard, see staff shortages and they have agency but not seen any impact on care, agency just take longer learning the ropes."

The senior team leader told us how the service was staffed, a team leader was on each shift and five care staff in the day and evening shifts and two staff at night. There were also management, catering and domestic staff. This was confirmed in records. The staff member said that there were some vacancies but these were being actively recruited to. In the interim agency staff and existing staff covered the vacant shifts. There were adverts for staff vacancies in the entrance hall to the service. Another staff member told us that there had been new staff starting and they were waiting for recruitment checks for other staff. They were over recruiting to ensure that short termed absence could be covered. Another staff member said that there were two agency staff on shift during our inspection, this was because of staff sickness. They said that the management were working to get fully staffed and said, "It will be nice to get full staff."

The minutes of a staff meeting in September 2017, identified that staffing and vacancies had been discussed.

Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

People told us that they were satisfied regarding the arrangements for their medicines. One person said, "Get pain killers when I need them, they are good at dishing them out if I need them, they stay with me whilst I take them." We observed staff administering medicines which were to be administered orally during the morning and lunchtime, and found that this was done safely and politely. MAR charts for these medicines were appropriately completed. There had been an incident regarding medicines not being available for a person which resulted in them requiring medical treatment in 2016. The senior team leader told us that the service had made a complaint to the agencies responsible for supplying medicines and systems had been put in place to reduce future risks. Following our inspection we wrote to the registered manager who provided information how they had learned from this incident to reduce future risks.

People told us that the service was clean and hygienic. One person said, "Housekeepers are very good and work hard, they are quite thorough, dining tables get cleaned two or three times day, got no complaints on the cleaning."

The service was clean and hygienic throughout with no unpleasant odours. All of bathrooms provided paper towels and hand wash liquid. Aprons and gloves for the use of staff to reduce the risks of cross infection were also available. Hand sanitiser was near to the front door with a sign, "Please help us to stay a healthy home by using hand gel below." Staff were provided with training in infection control, some staff needed this training updated who had received it in 2013 to ensure that they had received the most up to date information to minimise risks to people. Staff had been provided with training in food hygiene and

understood their responsibilities relating to this. The service had achieved the highest rating in a local authority food hygiene inspection.

Cleaning schedules were in place which showed that the service was cleaned to reduce the risks of cross infection. We saw records of wheelchair cleaning and commode deep cleaning.

One person's relative told us about how the service laundered their relative's clothing, "They are washing his trousers on too high a temperature, I spoke to the laundry [staff] and [they] told me by law they have to boil the clothes if these have faeces, we are having to buy lots of trousers." We spoke with the senior team leader who said that they ensured that soiled clothing was washed at an appropriate temperature to reduce risks. However, they had advised families of this and suggested they do not buy clothing that would be spoiled by this process. One person told us that they were happy with the way that their clothing was laundered, "They [staff] do two lots of washing every day." This supported the person to have clean clothing when needed.

Requires Improvement

Is the service effective?

Our findings

Effective was rated as Good at our last inspection of 7 August 2014. At this inspection of 1 December 2017 we found that Effective was now rated as Requires Improvement.

The systems in place to ensure that staff received the training they needed to meet people's needs were not robust. Staff had received recent training in moving and handling and supporting people with behaviours that others may find challenging and de-escalation. We saw that staff had commented about how this had assisted them in supporting people in a recent staff meeting which had resulted in reduced incidents. However, for other training, records showed that staff were not provided with updated training to keep their knowledge up to date to meet people's needs in the most effective way. For example four staff had received training in dementia in 2017. Records showed that other staff had not received this training since 2012. Staff had been provided with training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) in 2013, apart from four staff who had received the training in 2017. There had been changes in the law since this date and there was no evidence to show that these staff had received training in this. We could not be confident that they had the skills and knowledge to effectively meet people's needs.

This is a breach of Regulation 18; Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that staff were not being provided with regular one to one supervision meetings. These provide staff with a forum to discuss the ways that they worked, receive feedback on their work practice, identify ways to improve the service provided to people and to check on any further training needs. For example, one staff member's records identified that they had received a supervision in July 2017 and prior to this in 2013. Another staff member had received supervisions meetings in September 2017 and November 2016. The system in place to provide staff with support and to identify improvements in the care they provided was not sufficient. The senior team leader told us that they were working on making improvements in this area.

Despite the shortfalls we had found staff told us that they received training to do their job and were supported. The minutes of a staff meeting in September 2017, showed that discussions included that training was available to up-skill including taking blood pressures, checking sugars, Malnutrition Universal Screening Tool (MUST) and dementia. This would add to continual professional development. They were looking at skills for care developing care ambassadors attendance at events and conferences. This had not yet been fully rolled out.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw that staff sought people's consent before they provided any support or care, such as if they needed assistance with their meals, if they wanted to participate in activities and where they wanted to spend their time in the service. However, staff training in MCA and DoLS was not up to date. People's care records did not include people's capacity to make decisions, nor if any decisions had been made in people's best interests. One person's records said that they had a Lasting Power of Attorney in place but there was no information about what this meant for the person and which decisions the Lasting Power of Attorney made on behalf of the person.

One person's records showed that their family had declined for the person to receive medical treatment. There was no information in their care plan which identified their capacity to make their own decisions and if this decision had been made in their best interests with the consultation of health professionals. We spoke with a staff member about the lack of information about their capacity in care plans and their response showed a lack of understanding relating to MCA and DoLS. They advised us that the records included if people had dementia.

One person told us, "First year I was here I would go walking every day but the [registered manager] decided it was not safe for me to go and I told [registered manager] I was not happy. Month ago had a meeting and [registered manager] changed their tune… agreed I could go out on my own but weather not been good enough." The lack of records did not clearly identify how this decision had been made and changed.

This is a breach of Regulation 11: Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always provided with the food that they required to maintain good health. A person who received a softer diet was provided with a breaded mushroom. They did not eat this. When we pointed it out to a staff member they replied, "They [person] won't eat it." Another person told us, "Somebody slipped up yesterday and gave me chicken casserole, it had a good spoonful of onions and I must not have them, had to pick them out, I did not say anything, they have got a board up in the kitchen that says I must not have onions." Previously the catering staff had told us that this person's diet was catered for and separate meals were made. This was a risk because the person could not eat this item due to a condition.

People were asked for their lunch and evening meal choices for the following day during the mid-morning tea and coffee round. This could be confusing to people and especially those living with dementia who may not remember their choice or would prefer something else on the day. One person said that they did not want what was provided to them for lunch, when a staff member took it into the kitchen we heard a staff member say that this was what they had chosen yesterday. Staff then gave the person the same choice but without gravy, despite them saying they did not want it. Twice the senior staff on duty asked a staff member to prepare show plates for the person to make their choice, which was eventually done. One person told us, "Make your choice of food the day before and it helps them with the catering." Despite the fact the use of show plates had been identified by the management team as an improvement, this was not yet implemented. The current way of choosing meals was not person centred.

People's views on if their food was serviced hot enough varied. One person said, "Food is excellent, hot,

varied, sometimes I have soup when they have the fish and chips on." Another person commented, "Usually not hot." Another person told us, "Plenty of hanging around at mealtimes, sometime wait for half an hour and then the food is cold, the quality of the food is good, get ruined by delays." The delays in receiving lunch was also confirmed by another person, "Trouble with late meals, last 10 days, should be 12.15pm but been nearer to 12.45pm and we sit up at the table and wait, some of the [people] started singing 'why are we waiting'." During our inspection lunch time service commenced at 12.41pm. The services 'resident's handbook,' stated that lunch time was at 12.30pm.

We saw that the ways that the meals were served at lunch could be improved and to ensure that people's food was hot and they could start eating their meal when it was served. The vegetables were served in dishes on the table for people to help themselves to, these were covered in cling film. One person was given their meat on a plate, the vegetables had not yet been uncovered, so they started to eat their meat. Staff collected another three plates, one at a time, for people prior to the vegetables being uncovered, when this person could have their whole meal, but they had already eaten part of their meat.

This was a breach of Regulation 14: Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were provided with choices of food and comments varied about the quality. One person said, "Food for me is alright, I enjoy my food and got no complaints." Another person commented, "Food is very good, chef really know [their] job, get fresh veg every day." Another person told us, "Food is indifferent, sometimes terrible and sometimes remarkably good, plenty of fruit and veg, plenty of choice of food." Another person said, "The food is very good, choice of two dishes and I can come down or have breakfast in my room, can have jacket potatoes or omelette or soup if you don't like what is on the menu, they always try and find something for you."

Records of monthly weights were kept. Where issues had been identified, such as weight loss, guidance and support was sought from health professionals, including a dietician. For example, providing people with food and drinks to supplement their calorie intake.

Catering staff explained how people were provided with fortified diets, including high calorie drinks to maintain a healthy weight. In addition people had snacks to build their calorie intake. This was confirmed in records and our observations. The catering staff told us that there were monthly meetings attended by the people who used the service and the menu was always on the agenda. Any changes or preferences were fed back to the catering staff. They also told us that they sat with people individually to discuss their preferences. If people did not want what was on the menu they could have alternatives.

People's care plans directed staff to ensure that people were drinking enough fluids to reduce risks. There was no indication of how much drink these people were recommended to have. We did see that people were provided with choices of hot and cold drinks throughout the day of our inspection. This meant that there were drinks available for people to reduce the risks of dehydration.

People told us that they felt that their health needs were met and they were supported to see health professionals if needed. One person said, "They get the optician in, seen a doctor, chiropodist came the other day and the nurse comes and checks I am on the right amount of [medicine]." Another person commented, "I go to the opticians in town with my [relative], chiropodist comes, doctor comes." Another person told us, "If I have a problem I can talk to a senior and they will get a nurse."

A visiting health professional told us, "Come in every day, they are pretty good, take good care of the

resident's nutrition and personal care…Good communication from the senior staff, carers are friendly, residents seem happy."

We saw staff discussing the health of a person which resulted in the doctor being called. We saw records which were provided to other professionals if people required hospital admittance for example. These included important information about the person that other professionals needed to know about when providing care and treatment to people.

The staff in the service worked with other professionals involved in people's care to ensure that their needs were met in a consistent and effective way. For example, referrals were made to health professionals if the service were concerned about people's wellbeing. Records showed that referrals were made to other professionals where staff were concerned about people's wellbeing. This included with falls. However, these records were kept in a confusing way. They were on individual records kept together with incidents and accidents records and not in any order. There was no evidence to show that guidance or treatment had been incorporated into care plans or assessments to ensure that these were being followed.

People told us that they could use the communal areas and if they chose could have the privacy of their bedrooms. We observed that people's bedrooms had natural light and were personalised which reflected people's choices and individuality. The communal rooms consisted of the main dining/lounge room, a quiet room and conservatory room. There was a secure garden which people could choose to go into in the warmer weather.

There was a passenger lift and a small ramp which moved up and down to reduce the risk of people falling down the small set of stairs.

An ongoing programme of refurbishment and redecoration was in place, which was to continue in January 2018.

Requires Improvement

Is the service caring?

Our findings

Caring was rated as Good at our last inspection of 7 August 2014. At this inspection of 1 December 2017 we found that Caring was now rated as Requires improvement. This was because shortfalls identified during our inspection showed that people were not provided with a caring service at all times. This included the ways that meal times were organised, such as people waiting for their meals and how their choices and needs were promoted and respected. In addition the ways that people's consent was assessed and recorded provided a risk of people receiving a service that did not meet with their preferences and decisions.

There was limited evidence to show that people had participated in their care planning. The care plans did not include information about how people had been asked about the care they wanted and preferred, or had been involved in any care reviews to discuss their views, changing needs and preferences. One person's records included a document, "Preferred priorities of care," this was not completed. In another person's records this document was completed but was written in the third person. When we asked a staff member about this they told us it had been completed by their family. There were no records in place to show if this person had capacity to make their own decisions or not. A staff member told us that the service were working on improvements in involving people and families in planning their care and the priorities of care document had recently been introduced.

Despite the shortfalls in records people told us that the staff listened to and acted on what they said. We saw that people's choices were reflected in the times and location that people chose to have their meals. We saw a staff member walking with a person, they spoke with them in a caring way and listened to their choices. They said, "Where would you like to go?" Another staff member asked a person, "Do you want to go back to your room or stay here?" A staff member, whilst giving a person their medicines communicated effectively by maintaining eye contact and kneeling to ensure that the person understood what they were saying. They asked for their permission before moving their mobility aid from the table so they could attend to the person.

People spoken with said that the staff were caring and treated them with respect. One person said, "We cannot fault the care and the attention here, got nothing but praise for them, I used to voluntarily look after the gardens so when I needed to leave my home I chose to come here and would thoroughly recommend it." Another person commented, "Got a lovely shower of [staff], they work hard and are very keen on their jobs." Another person said, "They [staff] are bright talkative and we chat about personal things like family." Another person commented, "They [staff] chat to you all the time, they are excellent, friendly, kind, absolutely excellent." One person told us about when they were not feeling well and how staff supported them, "I was off my food and every day the chef came and saw me to see what I would eat…I was grateful and humble."

People told us that they felt that their privacy was respected when the staff wanted to enter their bedrooms. We saw that staff knocked on bedroom doors before entering. They ensured bedroom and bathrooms doors were closed when supporting people. When staff were talking with people about their personal care needs, such as if they wanted to use the toilet, this was done discreetly so could not be overheard by others. People

were offered aprons to wear whilst eating to reduce the risks of their clothing being spoiled. People were wearing hearing aids and spectacles where needed and their clothing was clean. Where people chose to wear items such as jewellery staff had assisted them with this. This demonstrated that people's choices and dignity were respected.

Staff talked about people in a caring and respectful way. Staff were all friendly, respectful, smiling and demonstrated meaningful relationships with people. We saw lots of interactions with laughter from staff and people. One staff member went into a person's bedroom, after knocking on the door, during the morning and said, "Good morning [person], would you like me to put the light on?"

We observed positive interactions during our inspection which demonstrated that people and staff shared positive and caring relationships. A staff member assisted a person to the quiet lounge because the person said that they felt sick. The staff member gave them a disposable bowl and tissue and spoke with the person in a compassionate way. The person said, "I am a nuisance," to which the staff member responded, "No you are not." They talked to each other about how the person felt and then the person told the staff member, "You are good to me." From their discussion they clearly shared a positive relationship.

One person said to a staff member, "I am very pleased to have you helping me," to which the staff member replied, "We are very pleased to have you here [person's name]."

We saw another staff member who had finished their shift and they sat and chatted with a person for 30 minutes before they left the service.

People told us how the staff respected their independence. We saw that staff encouraged people with their independence, such as when assisting them to mobilise and eat. We saw that people used equipment to assist them to eat their meals independently. One staff member supported a person with their breakfast and said, "Do you need a hand or can you manage? Just shout if you need me." Another staff member assisted a person with a drink and breakfast and said, "You going to have a cup of coffee? You try," the staff member handed a beaker with two handles. The staff member held one side and the person held the other. The staff member then said, "I am just going to wipe your face, would you try this fruit on the spoon, do you want to hold this?"

Staff understood why it was important to respect people's independence. One staff member said, "The [mobilising equipment] is simple but gives residents independence and makes it easy for them and for us, a brilliant piece of kit and helps maintain independence."

People told us that relatives could visit them when they wanted to which was supportive of people maintaining relationships with people who were important to them. There was a quiet lounge with drink making facilities where people could meet with their visitors in private. We saw people entertaining their visitors in this room during our inspection.

Requires Improvement

Is the service responsive?

Our findings

Responsive was rated as Good at our last inspection of 7 August 2014. At this inspection of 1 December 2017 we found that Responsive was now rated as Requires Improvement.

People's care plans included information to show that there were systems in place to review them on a monthly basis. However, three people's care plans had last been reviewed in September 2017. The review records included any changes however, these were not incorporated in care plans, which meant that staff would have to read through all of the reviews to receive the most up to date information about how the people's needs were met. This meant people were at risk of receiving care and support that was not appropriate.

The updates in care plans, where people's needs had changed, were not completed in a cohesive or clear way. For example the care plan for one person was typed and there were several entries in spaces on the document which were handwritten and did not add any context or guidance for staff. For example, on the original care plan "[Person] will eat sweets, cakes and biscuits given to other residents this will be monitored due to [person] being diabetic." Then two additions written in spaces on the document in January 2017, "[Person] sleeping more, eating and drinking less," and "[Person] to eat anything [person] likes." At the bottom of the care plan it stated it would be retyped in March 2017. This was the case throughout this person's care plan, there was no clear guidance for staff to show how their specific needs were met. There was a document which showed that the registered manager had checked the care plan in April 2017. There was no reference to show that the care plan required improvement.

Another person's care records stated that they preferred to have a bath. Then this was overwritten stating not to bath the person at this time. There was no further information why this was in place or to show that the person had been involved in the decision.

Another person's records provided inconsistent information about their mobility equipment. This ranged from a wheelchair, stand aid and hoist. This could be confusing to staff and there was a risk that the person could be receiving inappropriate care.

There was no information in the care plans about people's conditions, such as how dementia and diabetes affected them in their daily living. There was no guidance for staff about how they were to meet people's specific needs associated with their conditions. The records of one person who was living with dementia described their short term memory as, "Bad," and in the section for communication, "Likes a chat but due to dementia does repeat self quite a bit." There was no further information about how this affected the person and how staff should respond other than be patient.

One person's records included information about behaviours that may be challenging to others. There was no clear guidance about the triggers to this person's anxiety and distress reactions associated with dementia. This was despite records of reviews showing that the person was becoming more, "Confused," "Challenging," and, "Agitated." Records relating to behaviours used negative language such as, "Very rude,"

there was no further detail about in what way the person was seen as being, "Rude," what had caused this and actions taken to support them. There was no record or follow up or how the person was reassured. In addition further language used included, "Aggressive," "Verbal," "Agitated," and "Offensive language." The templates used to identify when people had displayed anxiety also used negative language including, "Aggressive behaviour" form, "Unreasonable behaviour" form and one document included, "Aggressive / offensive behaviour."

People's daily records varied in quality. There was a lack of detail about how the person's day had been and the time and quality of interactions by staff. Without this information it would be difficult for staff to track any changes in people's wellbeing.

A staff member told us that there were plans to review the care plans to be more person centred and reflect their needs. This had not yet been started.

All of the above is a breach of Regulation 17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people were at the end of their life there were systems in place to support people to have a comfortable, dignified and pain free death. In addition people's records, where people had chosen to discuss it, detailed their end of life wishes. This included if they wanted to be resuscitated and advance care planning where people had chosen to do these. However, not all people had included their choices. One person's end of life choices had been completed in January 2015 and an assessment had been completed in February 2014 and still referred to the previous registered manager and head of care. Their resuscitation choices had been completed in August 2014.

The manager told us that there was one person receiving end of life care. The minutes from a staff meeting in September 2017 identified that a person's relative had been so pleased with the end of life care they had provided to a person that they had a tea party to thank the staff.

Despite the shortfalls we had found in records, people told us that they were happy with the service they were provided with. One person said, "I am quite happy here, got no complaints and I find the staff alright."

We saw that the staff responded promptly when a person was unwell. They had noticed a change in the person and immediately went over to them. They spoke with another staff member to call an ambulance and sat with the person holding their hand. When the person was ready and able and when the emergency service arrived the person went to a more private area of the service. All of the staff were calm and professional. The person was treated with compassion and the way staff acted did not impact on any other people in the service.

People told us that there were social events that they could participate in. One person said, "Entertainment is good, like the carpet bowls. Puzzles and music." Later on we saw this person playing table and blow football with their relative. Another person commented, "Do handicraft and made Christmas cards and decorations which were quite effective, play floor bowls, singing, entered the sing for your heart competition, prayer morning, communion once a month, sit outside in nice weather, lady brought lambs from farm and duck eggs that hatched here." Another person said, "Entertainment groups come and we sing, outing to Felixstowe on the bus and take a packed lunch and go to a beach hut. It is quite well done."

One visitor told us, "Christmas Fair was a real team effort from staff and they donated things and we got two hampers, some residents manned stalls, we proved a free taxi service from the church to the home."

There was a notice in corridor promoting 'Sing for your life & Suffolk silver song project.' A person told us that people had entered this and someone came from the media and recorded their song. There were Christmas cards for sale which had been made by a person who used the service. They had an area in their room set up in a light area with their art equipment. This showed that people's interests were promoted and encouraged. There was a programme of activities in the service which identified how people's spiritual needs were catered for, including Bible study, prayer and reflection and devotional sessions. In addition other activities included pat the dog, movement to music, spa afternoon and board games. There were photographs of people feeding baby lambs and photographs of ducklings. Items of arts and crafts were in the service that people had completed, including peacocks and swans. There were several things in the service for people to use including books and magazines.

People told us that they felt comfortable raising concerns and complaints and were confident they would be addressed. One person said, "Any concerns I would initially speak to my carer or to whoever is on duty, I would feel comfortable speaking to them."

There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. The procedure was displayed in the service. In addition there were suggestion boxes where people could add their comments, anonymously if they chose. There had been no complaints received since June 2016.

Requires Improvement

Is the service well-led?

Our findings

Well-led was rated as Good at our last inspection of 7 August 2014. At this inspection of 1 December 2017 we found that the service had not maintained their Good rating. Well-led was now rated as Requires Improvement. The service had not kept updated with changes in the care industry, including staff training and the Mental Capacity Act 2005. The service had a history of compliance with inspections. However, this had not been sustained over the period since our last inspection.

The registered manager, who was registered with the Care Quality Commission in January 2016, was on leave during our inspection. We spoke with the senior team leader who was also the training coordinator and deputised in the registered manager's absence. Following our inspection we spoke with the registered manager on the telephone and they sent us their quality monitoring records promptly as requested. This was because staff could not locate them during our inspection visit.

The provider information return (PIR) had been submitted to us in October 2017 by the registered manager. They identified improvements they had planned for the next twelve months, which included reviewing policies and procedures, entertainment, reviewing care plans, increasing people's input into care plans, review of shift patterns and reduce agency staff. These were not yet implemented.

The manager's audits demonstrated that checks were made in the service. These audits included environmental checks, such as health and safety and up to date safety checks on equipment, such as hoists and fire safety equipment. The registered manager completed monthly auditing reports. The report from November 2017 identified that a person had been referred to the falls team following, "Frequent falls." In the overall comments section it stated, "Care plans need to be reviewed fully to ensure that all information is current. Overall plans need to be more comprehensive. Research and decide templates/format." It also stated that there was an introduction of show plates at meal times. During our inspection we did not see show plates being used during our inspection as routine. Although these improvements had been identified they had not been implemented yet. The audits had not identified the shortfalls in areas including consent, the Mental Capacity Act 2005 and meal times.

The quarterly trustees monitoring report from October 2017 showed that people, relatives and staff were asked for their views about the service. The report included environmental and records checks, identified actions needed and there was information when these had been addressed. For example, clogged guttering and the disposal of furniture and medicines checks, which had been addressed. However, this report had ticked satisfactory for the care records, our findings during this inspection identified that there were shortfalls in people's care records.

There was a falls register in place but no analysis to show that incidents had been used to drive improvement in the service. A staff member told us that there had been a change in senior staff in the service and they were committed to making improvements. They had set up systems to seek advice and guidance for best practice and advice on falls analysis.

The systems in place to monitor the service had not fully identified the shortfalls we found at our inspection. In addition the shortfalls the service had identified had not been implemented. This showed that the governance systems in place were not robust to provide people with a good quality service at all times.

All of the above is a breach of Regulation 17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were complimentary about the registered manager and how the service was led. One person told us, "Manager recently been appointed, is doing very well, stops and talks about anything you want to talk about." Another person said, "It is well run and they meet people's requirements and go out of their way for you." Another person commented, "I'm pleased to be here and would recommend it, very pleased my [relative] found this home for us."

There was a quality assurance folder in the entrance of the service, this advised that people could share comments and suggestions anonymously if they chose, in a suggestions box. There was information about the last quality assurance questionnaires, a summary stated there was a high level of satisfaction. However where there were comments of improvement needed these were discussed in staff and relative and resident meetings and actions taken. For example, a person was concerned about the water temperature and the valves were checked and adjusted. They had purchased standard lamps to assist people to read. There was an ongoing drive for recruitment. A forum was being set up for family and friends of people to give information and where they could share issues. There was a monthly resident meetings. The quality assurance information also shared that the service had made contact with a local school community group to visit with music. This showed that people's comments were valued and acted on.

People also shared their views about the service in meetings. The minutes of a meeting in November 2017 identified that people were kept updated on staffing, recruitment, the decoration programme in place and discussed the menu and activities. One person said, "Meeting every month for the residents, we talk about mash potatoes, everyone likes them I get fed up with mash so I ask for a jacket potato and have that, we talk about anything we grumble about and they listen and do change things, boss is effective at meeting people's needs." Another person commented, "We have residents meetings and they [staff] ask if there is anything we want changed on food, tell us of special events, news from our church and one carer is allocated to getting residents ideas."

Family forum meetings had been introduced in June 2017 and held in September 2017. They discussed staffing and how they were recruiting, encouraging involvement from family and friends, that they had started the preferred priorities of care and activities. The next meeting was to be held in January 2018.

Staff meetings were held. The minutes of a staff meeting in September 2017 stated that a previous meeting in August had been cancelled due to staff not attending, they were advised the importance of attending these. Discussions were held about staffing levels and changes. There were a range of staff meetings held including senior and catering meetings.

Staff were complimentary about how the service was led. One staff member said, "[Registered manager] and [senior team leader] are very good." They said that they would have no hesitation in reporting any concerns or bad practice to them and if they did not feel this was listened to, "The trustees, they run the home, I would go to them with any whistleblowing if needed." One staff member told us how there had been changes in the staff team which had improved the atmosphere. They said, "[Staff] are a nice bunch now, the [registered] manager is approachable and easy to talk to, [registered manager] has done the job and knows where we are coming from. [Registered manager] dealt with an internal problem with another staff member who was

a good worker but not good with other staff not a team player," and, "Got new [staff] in and the atmosphere is lovely and nice and it is nice to come into work."

The service's staff worked in partnership with other professionals. This included seeking advice and guidance from professionals involved in people's care. They also worked with other community services to support people's activities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The systems and processes in place relating to people's consent and the Mental Capacity Act (2005) were not robust. Regulation 11 (1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The systems in place for assessing and mitigating risks to people who used the service were not robust. People's medicines that were to be applied externally were not recorded appropriately to show these had been administered as prescribed. Regulation 12 (1) (2) (a) (b) (c) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's dietary needs were not always met. Regulation 14 (1) (2) (a) (b) (4) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance The systems and processes in place to assess, monitor and improve the quality of the service provided to people were not robust. Improvements were required in how the service assessed, planned for and kept records in relation to the care provided to people. Regulation 17 (1) (2) (a) (c) (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not provided with up to date training to meet people's needs effectively. Regulation 18 (1) (2) (a).