Harbour Care (UK) Limited

# Coral House

## Inspection report

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06 November 2017
08 November 2017
09 November 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

The inspection was unannounced on 6, 8 and 9 November 2017. At our last comprehensive inspection in March 2017 the service was rated 'inadequate overall' and was placed in 'special measures'. We identified seven breaches of the regulations including four repeated breaches of regulations from the previous inspection in December 2015.

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

We served a warning notice for the breach of the regulations at the March 2017 inspection in relation to the care people received. We inspected the key question 'Is the service Responsive' in June 2017 and found improvements in how responsive the service was and the care that people received. The registered provider agreed to send us a monthly action plan as to how they were meeting the regulations. This was provided every month as required. However, the action and progress plans did not accurately reflect the findings of this inspection.

At this comprehensive inspection the improvements found in June 2017 had not been sustained and we found five breaches of the regulations and two new breaches of the regulations in relation to complaints and consent. There were significant improvements in the cleanliness of the home and there was an ongoing planned programme of refurbishment.

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

There was no registered manager at the service. The previous registered manager left the service following the March 2017 inspection. A new manager was appointed and was in post at the June 2017 inspection. However, this manager left the service in September 2017. There was an acting manager who had been in post for three weeks at the time of this inspection, who is a registered manager for another of the registered provider's care homes in Poole. 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.

Some people had not been consistently kept safe. This was because actions had not been taken in response to safeguarding incidents and risks to people were not fully assessed and managed. There remained some shortfalls in the management of people's medicines.

Some people's health care needs had not been met or followed up with health care professionals. People's care plans were not consistently followed or updated when people's needs had changed. People's food and fluids and weights were not accurately monitored and reviewed to make sure they kept well. The records kept about some people were inaccurate and incomplete.

There continued to be a high turnover of staff and some staff did not have the skills and knowledge or had been trained to be able to meet people's needs.

Staff did not fully understand the principles of the Mental Capacity Act 2005 and best interests' decisions were not in place for some people. Some people signed their consent to written care plans they did not understand.

There were complaints procedures in place but not all complaints had been investigated or responded to.

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

Staff were caring and treated people with dignity and respect. People and staff had good relationships. People had access to the local community and had individual activities provided. People were involved in planning, shopping and preparing their meals.

The houses were clean and there was a planned programme of refurbishment. People had been involved in choosing the new furniture and décor.

There were improvements in how accessible information was for those people who communicated differently.

The acting manager and operations director took action to address any of the shortfalls identified during the inspection. They had started to implement changes at the home but these had not yet had much impact on the people because they had only been in post for a short period of time.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

People were not consistently kept safe at the home.

People told us they felt safe and staff were trained in how to report any allegations of abuse.

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

The management and administration of medicines was not consistently safe.

Information obtained about agency staff showed they were recruited safely.

Learning from incidents, safeguarding and complaints was starting to be shared with staff.

### Is the service effective?

**Inadequate**

People's needs were not effectively met by staff who had been well supported and fully trained.

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

One person did not receive their dietary supplements as prescribed.

There was an improvement and understanding of Deprivation of Liberty Safeguards (DoLS). DoLS applications had been submitted and reapplied for as required.

### Is the service caring?

**Requires Improvement**

Overall, the service was caring but improvements were needed. This was because staff had not been trained to communicate with one person.

People and most relatives told us staff were caring.

Staff understood how to provide care in a dignified manner and

respected people's right to privacy.

Family and friends were made welcome at the home.

## Is the service responsive?

**Requires Improvement**

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

People's care plans were not always updated and did not include sufficient information about their care and support needs. This meant staff did not have up to date information about how to care for people.

People and relatives knew how to make a complaint but not all complaints were investigated or responded to.

## Is the service well-led?

**Inadequate**

The home was not well led.

The governance systems were not effective and the multiple changes in managers meant the service had not made the improvements identified at this and previous inspections.

# Coral House

**Detailed findings**

## Background to this inspection

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

This unannounced inspection took place on 6, 8 and 9 November 2017 and was conducted by one inspector.

We met and spoke with the six people who lived at Coral House and used Makaton (a type of sign language) with one person. Some of the people we met had complex ways of communicating and were not able to tell us their experiences of the service. We observed staff supporting people. We also spoke with the operations director, acting manager, quality improvement lead, the maintenance worker and five support workers.

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

We did not request a Provider Information Return (PIR) this was because we received one in January 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also looked at incidents that they had notified us about. We contacted commissioners and health and social care professionals who work with people using the service to obtain their views. We received email feedback from one person's relative prior to the inspection and following the inspection we received email feedback from two people's relatives.

Following the inspection, the operations director and acting manager sent us information about the internal compliance assessment, new management structure and plan, information about one person's transition arrangements, the training staff had received and the staff training plan.

Inadequate

# Is the service safe?

## Our findings

At our inspection in March 2017 we made adult safeguarding referrals to the local authority as a result of the concerns we identified during the inspection. This was because we identified serious concerns and shortfalls about the safety of three people. These people had not received the care and treatment they needed and actions had not been taken in response to people's changing needs. The registered manager and staff had not recognised that people were at risk of harm and neglect and had not made appropriate referrals to the professionals involved and raised safeguarding alerts. This was a breach of regulation 13.

At this inspection, the previous manager and provider representatives had made safeguarding alerts to the local authority as required. The managers and provider co-operated fully with the local authority safeguarding team but the safeguarding risk management plans agreed were not consistently implemented. For example, one person told us, "I feel safe now. Not worried about getting hurt." This was because at the end of September 2017 appropriate safeguarding risk management plans had been put in place. However, prior to this there had been a significant delay in taking action to safeguard this person who was subject to harm from another person.

Concerns were raised with us that the actions agreed following local authority safeguarding investigations in April 2017 and July 2017 had not been implemented. The risk management plans put in place following each incident were not effective. This meant the measures put in place failed to keep the person safe and this resulted in repeated incidents where the person was at risk of potential and actual harm. These shortfalls in safeguarding people from abuse were a repeated breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, who were able to, told us they felt safe and two relatives said they did not have any concerns about the safety of their family members.

There were posters displayed in the communal areas and office in both houses about how people and staff could report any allegations of abuse. These were supported by pictures to make the information easier to understand.

At our inspection in March 2017 risks to people's safety were not consistently assessed and managed to minimise potential harm. Action was not taken in response to risks or changes in people's needs such as contacting the health and social care professionals involved with people. This was a breach of regulation 12.

At this inspection, there were some improvements in some people's risk assessments and management. However, there were still some areas of risk that were not fully assessed or mitigated. For example, one person's positive behaviour support plan did not reflect some of the person's new behaviours. The person told us they were unhappy with the staff's response to a recent incident where they were very angry and upset. They said, "They wouldn't leave me alone, I don't want to get angry but staff wouldn't leave me alone. They put their foot over the doorway even though I asked them not to and that I needed to calm down". The acting manager agreed to discuss with the person and agree a new positive behaviour support plan.

In March 2017 we identified that an occupational therapy referral for this person had not been followed up. This was so the person could be assessed for a hand splint for their hand contracture. At this inspection the occupational therapist referral had still not been followed up for this person.

The person's healthcare records showed their GP was making a referral in March 2017 to orthotics as their feet were rubbing on their shoes and causing pain. There had been no follow up on this referral and the person had not been seen by the orthotics department. The person told us they had pain but they had stopped taking their pain relief and other medicines because they were not working. The acting manager had updated the person's GP and health and care professionals about the person's reluctance to take their pain relief medicines.

In addition, the person had not been weighed since August 2017 because they did not wish to leave the home. In March 2017 the person's community dietician had recommended that alternative calculations, such as Mid Upper Arm Circumference (MUAC) should have been used. This was so staff could have monitored and assessed how much weight the person had lost if they were reluctant to be weighed. MUAC is a measurement that allows staff to calculate a person's weight and Body Mass index. The operation director took immediate action and provided the staff with MUAC guidance so they could calculate the person's current weight.

Another person had a complex health condition that required them to drink a set minimum amount of fluids each day to reduce the risks of them fainting. This risk was identified by the person's relative in May 2017 following a consultant appointment. A care plan was written reflecting the person needed to have the minimum amount of fluids. However, no action was taken to monitor and encourage the person to drink the minimum amount of fluids. The person reported to staff in their monthly review meetings that, 'I sometimes pass out' and this information was shared at their consultant appointment. This meant the risks to the person's safety and well-being were not monitored or managed.

This person used an oxygen concentrator every night whilst they slept. The filter needed to be washed every week to reduce the risks of the person inhaling dust and to keep the machine functioning properly. At the inspection in March 2017 this was not being done. Following the inspection, staff were trained in the use of the concentrator and an oxygen plan was written. This included that staff were wash the filter with the person on a Monday and record this on the person's medicines records. Staff and the person told us they thought the filter was being washed weekly but could not be sure where it was recorded. No records were found to evidence this risk was being managed. The acting manager took immediate action to implement fluid recording and monitoring for this person. They amended the newly implemented oxygen monitoring records to include the weekly washing of the filter.

These shortfalls in full assessing, monitoring and managing the risk to some people were a twice repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in March 2017 people's medicines were not always safely managed or administered and this was a new breach of the regulations. This was because some people did not have their creams applied and medicines as prescribed and staff did not have clear instructions when they needed to give some people 'as needed' medicines or topical creams. The advice of the pharmacist had not been sought for one person's covert medicines. This was a breach of regulation 12.

At this inspection, there were some improvements in how people's medicines were managed and administered. The advice of the pharmacist had been sought in relation to the crushing of tablets and adding to foodstuffs to make sure that it did not change the composition of the medicines. The acting

manager had introduced body maps to indicate where people's creams should be applied. Overall, the recording of the administration of medications had improved but there were still some inconsistencies in the way staff recorded and or gaps in people's medicines administration records (MAR).

One person's prescribed nutritional supplement drinks had been signed for on their MARs twice a day. However, the person's food and drink monitoring records showed the person was only being given one supplement drink a day. The records showed that the person was not always drinking the prescribed supplement drink. This meant the MARs were not accurate. This shortfall was also identified at the inspection in March 2017.

Most staff had now received medicines training. The acting manager had identified that five of the 10 staff who administered medicines needed to have their competency re-assessed. This was in line with the provider's standard and policy of assessing staff medicines competency every six months. They had a plan in place to complete these reassessments.

The shortfalls in medicines management were a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in March 2017 some areas of the houses and people's equipment were not kept clean and or were damaged and this increased the risks of the spread of infection. This was a breach of regulation 15.

At this inspection, there were significant improvements as both houses were clean and the sofas in Coral House 2 had been replaced. The flooring in Coral House 1 was being replaced during the inspection. People told us they had helped to choose the flooring and the new sofas that were on order. There were new cleaning schedules in place and checks to see that these had been completed were included on the newly implemented daily handover records. However, prior to the new handover records being developed the cleaning records had not been consistently completed. For example, one person's bedroom cleaning record for October 2017 had 13 days when the record was not completed to show the room was cleaned.

At our inspection in March 2017 there continued to be shortfalls in the records kept about people and the management of the home. Those shortfalls were a repeated breach of the regulation 17.

At this inspection, there were continued shortfalls in record keeping. For example, some people's care and monitoring records had gaps, some entries were not named and dated, some had the incorrect name of the person and one person's health appointment record had been started but was incomplete so it was not known what the outcome of the appointment was. Health and social care professionals also fed back concerns about the standard and quality of the records for people. This was a twice repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager had started to manage the performance of staff who were not completing records as required. Staff, from the other care home the acting manager's was the registered manager for, had given guidance and example records to the staff at Coral House so they could see how records should be completed. The acting manager had been consulting with the staff that knew people well and was starting to introduce personalised records for each individual. The manager's plan was to ensure if the person needed specific information monitoring and reviewing there would be a personalised document template to support this. For example, one person needed their bowels monitoring so staff knew when to administer any as needed medicines for their bowels.

Some people had identified at a 'Your Voice' meeting that they wanted to be more involved in their own

record keeping and staff planned to complete people's records with them so they could contribute to what was being recorded.

There had continued to be a high number of staff and managers leaving Coral House since the inspection in March 2017. For the year up to October 2017 there were 13 staff in total who left the home. The provider's human resources department had contacted staff and established the inconsistences in management at the home had contributed to staff's reasons for leaving. Agency and bank staff were used and where possible regular staff who knew people well were used. People who were able to told us they knew most of the staff and told us they liked some of the agency staff. However, one person's relative raised concerns about the ongoing use of agency staff. The acting manager informed us that one person was due to move to another placement within the next few weeks and this meant the service would then be fully staffed.

There were no new staff recruited since the last inspection, so we did not review any staff recruitment files. We reviewed the profiles of the agency staff and they included evidence of reference checks and criminal record checks.

People were not consistently supported by a staff team that had the competence and skills to do so. In addition, consideration had not been given to the skill mix on duty and who was allocated to work with each person. For example, there were not always staff who had been trained in positive behaviour support allocated to work with one person who had positive behaviour (PBS) support needs. Some bank staff had not received all of the provider's core training or PBS training to be able to meet people's needs. This shortfall in some staff's skills and competence was a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing was calculated on people's individual needs and the acting manager ensured that where people were funded for one to one or two to one staffing this was provided. Each day staff were allocated to work with specific people. People and the acting manager were exploring some people's preferences as to how they wanted to use their funded one to one hours. One person told us they were looking forward to having one to one time with staff in the community rather than using their one to one hours in a car going to their day service. This person's relatives also fed back to us their positive views on the acting manager's action in relation to the funded one to one hours being better used for the person.

Incidents and accident reports were now being submitted electronically within 48 hours and reviewed on daily basis by provider's quality improvement lead and operations director. However, prior to this the acting manager had identified there had been up to 23 days before incidents were submitted electronically. This meant the operations director and quality improvement lead would not have been aware of them to be able to review and respond to them in a timely way. The previous review of some incidents had not resulted in changes to people's care and or risk management plans or staff practices.

Lessons learnt following a recent safeguarding incident had been discussed at the first team meeting held by the acting manager in October 2017. However, we were unable to find records prior to this date that lessons learnt following safeguarding, incidents or complaints that had been discussed and shared with the staff team.

The operations director informed us that lessons learnt following a complaint from a relative of a person who had previously lived at Coral House would be shared with the staff team. This was so they could understand the experiences of the relatives and person whilst they had been living at Coral House and improve their practices. Actions had been identified to minimise the risk of re occurrence following the investigation of the complaint. These actions were in the process of being implemented but this was not yet

complete.  They also told us that at a full review would be completed at the provider level in relation to the ongoing shortfalls identified at Coral House and any lessons learnt about the ongoing shortfalls for people would be shared across the organisation.

There were personalised emergency fire evacuation plans in place for people. There were other emergency procedures in place for people, staff and the building maintenance. In addition, there were weekly maintenance checks of the fire system and water temperatures.

There were systems in place for the maintenance of the building and equipment. A member of staff was employed to keep up with general maintenance and repairs across the provider's homes in the local area. They were working in the home during the inspection. They had made sure that people were involved and kept up to date with the planned works. They had co-ordinated the works so there was a minimum disruption to people. Most people chose to go out for the day whilst the flooring was being replaced. The operations director informed us they were advertising for another full time maintenance worker to work alongside the current member of staff. This was due to the amount of ongoing maintenance in the provider's care homes in the local area.

Inadequate

# Is the service effective?

## Our findings

At our inspection in March 2017 staff had not received the training they needed to be able to meet people's needs. These shortfalls were a breach of regulation 18.

At this inspection, most staff had completed their core training. All of the agency staff had received core and specialist training in positive behaviour support (PBS) strategies. However, some staff employed had not yet received the specialist training identified to meet people's specific needs or all of their core training. Three of the 10 staff had not received training in positive behaviour support. Some of the provider's bank staff had not completed all of the core or specialist PBS training. The acting manager agreed to review the staffing rotas to ensure that only staff who had to been trained in PBS supported one person.

These shortfalls in staff training to meet people's needs were a repeated breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager sent us a training plan that identified all staff training shortfalls should be met by February 2018.

At this inspection, most staff had not consistently received one to one supervisions from the previous managers. There were records of group supervisions and individual staff appraisals. However, we were told by the acting manager that these appraisals were not completed in line with the provider's procedures. The acting manager had produced a plan to supervise all of the staff and in the short term. Until the service stabilised, they and the new deputy manager would supervise staff on a monthly basis. We have not yet been able to assess whether this could be achieved and sustained.

At our inspection in March 2017 people's needs were not reassessed when their circumstances changed and care plans were not updated or did not include all the information staff needed to be able to deliver the care for people. The topic areas relating to this concern were under the key question of Responsive in the previous assessment framework, but were moved to this key question when the framework was reviewed and refined.

At our inspection in March 2017 we also identified some people's care needs were not always met because the healthcare they needed was not arranged, followed up or delivered. These shortfalls were a repeated breach of regulation 9.

There were some improvements in the assessment and meeting of people's health needs seen at the June 2017 warning notice follow up inspection. However, this had not been sustained and at this inspection there were again shortfalls in assessing, planning for and meeting people's health and care needs.

For example, the positive piece of work completed in June 2017 to reassess and understand one person's perspective of their life had not resulted in staff delivering all of the care and support the person needed. In addition, there were not any specific assessments or plans on how staff were to support, monitor and deliver

skin care to the person's contracted hand and their other susceptible pressure areas. A staff member was knowledgeable about how and the times the person was accepting of personal care. However, there were not any specific assessments or routine checks of the person's hand and nails to make sure the skin on their hand was not damaged.

This person had very clear support plans and records in place in relation to their nutrition and hydration but these had not been consistently followed or the records completed due to a change in the person's wishes. At this inspection, the previous and acting manager had kept the health and social care professionals updated as required following a change in the person's eating habits.

Health and social care professionals told us they had reluctantly had to withdraw their support for a second person who was having unusual sleep patterns. They said the repeated changes in staffing and managers had impacted on the staff's ability to consistently follow the assessments and deliver the plans they had put in place. This meant they had not been able to evaluate the effectiveness of the plans and impact on the person's sleep patterns. We found the night time low stimulus plans and the step by step recording format the professionals had recommended were still not being followed and were not easily accessible to staff. The acting manager took immediate action to make sure staff had access to the step by step plans, processes and recording.

A third person had a complex health condition and they were under the care of a specialist consultant. The person's relative told us the person had not had blood tests as required prior to their consultant appointments. Following the person's appointment in March 2017 a 24 hour blood pressure monitoring was requested prior to their next appointment in September 2017. However, this monitoring had not been requested from the GP or completed in preparation for the appointment. The records showed this had not happened.

In addition, concerns had been raised about the person's significant weight and BMI increase and the impact that this had on their health. In May 2017 the person's relatives had identified during a care plan review the need to consider the person following a healthy eating plan. No action had been taken in relation to this and there were no records of the person being weighed or their weight being monitored at the home. The only record of the person's weight and BMI was on the consultant's follow up letters to the home. The latest appointment in September 2017 showed the person's weight and BMI had increased significantly since their previous appointment.

Another health professional had asked the staff at the home to monitor another aspect of this person's health following a change in medication. This had not happened and this aspect of their health care had not been planned for.

Some information about people's medicines and health conditions was incorrect. For example, two people were prescribed medicines for hypothyroidism. However, their medicine and health care plans made reference to them having hyperthyroidism and listed the symptoms of this condition. Important information about one person's specific antibiotic regime that was related to their health condition had not been flagged in their medicines plans or records. This meant staff did not have easy access to this information. The acting manager took immediate action to update this information.

These shortfalls in people's needs being effectively met were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager had started to introduce a more robust way of recording and reviewing people's health

appointments. This included a year to view document so staff could easily see and track people's health care appointments. This had been completed for one person.

The acting manager and operations director acknowledged the serious ongoing shortfalls in the meeting and following up on some people's health care needs. This was because some people's health care records were incomplete, confusing and some important information was lost because it was only known by staff and managers who had left. The acting manager had arranged for people's health needs to be fully assessed with their GP, was consulting with people's relatives and planned to reassess people's health action plans with people. We are not yet able to assess the impact this will have on people's health needs being met.

At our inspection in March 2017 some people needed their foods and fluids monitored because of their complex health needs and because they were prescribed dietary supplements. However, action was not taken when shortfalls in people's nutritional intake changed, they were not having their prescribed dietary supplements and/or there were gaps or inaccuracies in their monitoring and medication records. This was a repeated breach of regulation 14.

At this inspection, we followed up on one person who had complex needs and was supported by a multidisciplinary professional team including a learning disability nurse and community dietician. The person's eating habits had again deteriorated significantly since our inspection in June 2017. Their food and fluid records for October 2017 showed the person had only been eating snack bars and because they had not being going out daily with staff as specified in their care plan they had not eaten a cooked meal on those days. In contrast, the week of the inspection the staff consistently followed the person's care plan and there were improvements in the person's eating and drinking.
The records for October 2017 also showed this person had not routinely been having their prescribed nutritional supplement drinks. These had been signed as administered twice a day on the person's MAR sheets but the food and fluid records showed they had not routinely been drinking them. The food and fluid records had not been completed fully and had gaps in the recording. There was no system for totalling and reviewing the food and fluids. This meant staff at the home did not have a daily overview of what the person had eaten and drank including their prescribed dietary supplements. This shortfall was first identified in December 2015 and this was a twice repeated breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were improvements in how some people were being involved in planning and choosing their meals. Photographic recipes were used with people to plan the menu which was then displayed using photographs and pictures. One person, who lived in a separate suite in Coral House 2 told us they were now planning a healthy eating plan and menu. This involved them shopping for the meals with staff and preparing them with staff.

At our inspection in March 2017 two of the people living at the home were unlawfully deprived of their liberty. The registered manager had not recognised the risk of deprivation and made applications for a deprivation when these were required. This was a breach of regulation 13.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection, there was an improvement and understanding of DoLS. DoLS applications had been submitted and reapplied for as required. Two people's DoLS had been authorised with conditions. The

conditions in place for one person had been met and the conditions for another person were in progress as the DoLS authorisation had only been received three weeks before the inspection.

Staff did not fully understand the principles of the Mental Capacity Act 2005. For example, one person had signed their health care plan that was in a written format but the information included in the plan about their health conditions was incorrect. This meant the person had been asked to consent to and sign to a care plan that was inaccurate and was not in a format they could understand.

Another person told us they wanted to have their own phone, they said, "No-one sorts it out and I feel like just going out to get one". This decision or the person's mental capacity in relation to this had not been assessed in line with the principles of the MCA. There were not any details recorded in the person's care records as to why this restriction was in place. The person agreed for us to raise this with the acting manager. The manager told us following the inspection they had followed this up with the person and was exploring this with the professionals involved with them.

The shortfalls in staff's understanding of MCA and consent was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was having a planned move to a new care home closer to their family. There was a comprehensive transition plan in place that included staff from their person's new care home working alongside Coral House staff. The acting manager was proactively working with health and social care professionals and the new staff working with the person to ensure a smooth move for them, this was particularly important because the person had complex needs.

People had been consulted and involved in choosing the décor and furniture in Coral House 1. One person also told us they had chosen the colours and decor in their bedroom.

The conservatory where people sat at the table to eat their meals was cold. People and a visitor told us there had previously been a heater in the conservatory but this had been removed as it was deemed unsafe. The manager advised us following the inspection that the dining room table had been moved into the lounge, which is large enough to accommodate this, so people could eat their meals in the warmth.

Since the last inspection, a new wet room had been installed in Coral House 1. The acting manager told us there had been plans by the previous manager to convert the other bathroom into another wet room. However, following consultation with people and one person telling us and the acting manager, "I'd rather have a hot bath", the plans were put on hold so the putting in of an accessible bath could be explored.

Requires Improvement

# Is the service caring?

## Our findings

At our inspections in December 2015, March 2017 and June 2017 staff had not been trained in Makaton so they could effectively communicate with one person. The topic areas relating to this concern were under the key question of Effective in the previous assessment framework, but were moved to this key question when the framework was reviewed and refined.

At our inspection in June 2017 we were informed in writing by the provider that Makaton training would be provided to staff. However, this training that had been agreed was not provided to staff. This training has now been rebooked. This meant most staff were still not able to fully communicate with one person who used Makaton to communicate. This was a repeated breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to told us that staff were caring and they liked most of them. A relative said the staff had continued to be caring and compassionate. Staff showed genuine concern and care for people's well-being.

Some staff were concerned about the turnover of staff and managers but remained committed to caring to the people, some of whom they had worked with for a number of years. Some staff told us there had been multiple different styles of management and this had at times made it difficult to work as a team.

Some people's need for emotional support was not always recognised. For example, one person's parent had died less than a year ago. There had not been any discussions with the person about whether they wanted to be offered or be referred for any grief counselling. The acting manager agreed to discuss this with person.

The service had not consistently supported people to be actively involved in making decisions about their care or consulted with their representatives who may be able to help them understand. In response to this, the acting manager was meeting with people and their representatives to improve people's and or their representative's involvement where appropriate. Two relatives and one person who had met with the acting manager and the operations director fed back that they felt they had been listened to. They were positive about the support and plans being offered by these staff.

People's preference in relation to gender of care worker was recorded. The majority of the time this was respected. However, one person's relative was concerned that the person's preferences had not been met on one occasion. This was the subject of a complaint. The person confirmed to us they only wanted 'ladies' to help them in the bath and that 'ladies' helped them now.

People and their relatives told us they were made to feel welcome when they visited their family member.

Staff respected people's privacy, they knocked and sought people's permission before going into their bedrooms, private spaces and acknowledged that they worked in people's home. Staff who worked with

one person on a two to one basis respected the person's need for time alone in their bedroom whilst still maintaining discrete observations that were not intrusive. Three people who were able to told us staff always asked before they went in their bedrooms.

Staff maintained people's dignity during the inspection. One person chose to wear little clothing and staff ensured their dignity in our presence. Another person needed some support with personal care and staff noticed this and discreetly assisted the person.

People told us staff helped them with their personal appearance. For example, one person liked to colour their hair and staff helped them with this. Another person liked their nails painted and to paint the nails of the staff. However, one professional fed back concerns about another person's hair care and sometimes they had not been shaved.

People were encouraged to be independent. For example, some people assisted with their meal preparation, laundry and cleaning. One person had recently moved into an independent living suite within Coral House 2. They told us they liked living in the new suite and having more independence but they said, "I still need help with things". The person's relatives identified that sometimes staff assumed the person was more capable and independent than they were. The relatives said that this had sometimes left the person feeling frustrated. The person and acting manager told us they had all discussed this and this was being addressed with the staff team.

Requires Improvement

# Is the service responsive?

## Our findings

Some people's care plans did not fully reflect their physical, mental, emotional and social needs. For example, at our inspection in June 2017, a piece of work had been completed with staff and one person that acknowledged and recognised their views and feelings. However, this had not resulted in a person centred approach to planning to meet their needs. This was because consideration had not been given to their social history, loss of close family members, their important personal relationships, potential pain from their health conditions and their reluctance to eat, drink and take pain relief.

Another person's care plan did not reflect their changing needs in relation to their dental care. The person's relatives had identified in writing a deterioration the person's dental health following a dentist's visit. However, no action had been taken or plans put in place in response this area of concern.

People and relatives had been involved and consulted about some elements of planning their care but this had not been consistent. For example, some parts of one person's care plan had been shared with their relatives who had commented and added some additional information to them. However, the care plans were not in an accessible format for the person and as previously identified this had resulted in them signing to agree to an inaccurate plan.

These shortfalls in consulting with people and planning for meeting people's needs and preferences in a person centred way were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager had arranged to meet with or contact people's relatives and representatives (where people either agreed to them being involved or they were their representatives) to consult them about people's care plans. One person and their relatives told us they had already had a meeting with the acting manager and they had confidence they would move things forward for the individual.

The acting manager planned to involve people and staff in producing an easy to follow summary of their needs and they support they needed so that all staff, including agency and bank staff, had clear easy to follow information as to the person's care and support needs.

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

Most complaints had been investigated and responded to in line with the provider's complaints procedures. However, a relative contacted us in September 2017 to inform us of some concerns and that a formal complaint they had made in July 2017 had not been responded to. They informed us again during this inspection that they had still not had any response to their complaint. We fed this back to the operations manager on the last day of the inspection who took immediate action to write to the complainant and complete the complaint investigation that had been started by the previous manager.

This shortfall in operating the complaints procedures was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning from previous complaints investigations had not yet been shared with staff. The operations manager planned to share the significant learning from one complaint from a previous resident's relatives with the staff team. This was planned so the staff team would fully understand the experiences of the person and their relatives whilst they had lived at Coral House.

People had a weekly plan of activities that was based on their personal preferences. This included activities in the home and in the community for most people. Some people attended day services. Some people were choosing not to access the community on a regular basis. Relatives fed back that there could be more imagination and opportunities to keep people occupied and stimulated especially at weekends.

People were supported to maintain important friendships and relationships. One person told us their partner visited for tea. Other people's relatives visited them and or they went to stay with them. Some people maintained contact by telephone. One person told us they wanted staff support to contact one of their relatives who they had not been contact with for a while. The person was happy for us to discuss this with the acting manager so they could follow this up.

During the inspection people accessed the community to go shopping, have meals out with staff, and have day trip because the flooring was being replaced.

The acting manager was taking action to make sure they were meeting the accessible information standards. For example, using Picture Exchange Communication Symbols (PECS), photographs on kitchen cupboards and using a photographic menu. People had been given information about flu jabs in a pictorial format. This was so they could understand and make an informed decision about whether they had a flu jab or not.

The acting manager was also planning to use 'social stories' to assist people with their understanding of things. These are short descriptions of a particular situation, event or activity, which include specific information about what to expect in that situation and why. This can be written or supported by pictures and photographs. We have not yet been able to asses this impact this will have on people's understanding of information.

Inadequate

# Is the service well-led?

## Our findings

At our inspection March 2017 the home was not well-led. This was because the governance at the home was not effective and there had not been any consistent effective management at the home to drive improvements. Relatives and health and social care professionals also raised concerns about the frequent change in managers, communication systems and staff turnover at the home. This was a breach of regulation 17

At this inspection, the service was still not well-led. The provider's governance systems had not been fully effective. The monthly updates and action plans submitted to us did not accurately reflect the progress on meeting the regulations and improving the quality and safety of service for some people. The provider's audits and check had not identified the shortfalls we found during this inspection. The multiple managers and senior managers have impacted on the service's ability to identify accurately the ongoing shortfalls, move forward and make the improvements required to ensure that people received a safe, effective, caring, responsive and well-led service.

Since September 2017 there has been an increase in concerns raised with CQC. We had received concerns about the ongoing changes in the management of the home. Some relatives and professionals told us they had had little confidence in the provider because of the constant management and staffing changes at the home.

There have been four changes in managers working at the home since the inspection in March 2017 when the service entered special measures. In addition to this there have also been three different line managers for these managers following changes in the provider's management structures and regions responsible for the home. As part of the provider's changes this included changes to the operation's director and quality improvement lead responsible for Coral House in July 2017.

The governance systems in place included independent financial audits, internal compliance inspections and weekly and monthly audits by staff and managers. However, the audits and checks had not been double checked by the provider, nor did they identify the shortfalls found at the inspection or accurately feed into the action plans submitted to CQC.

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

The provider has recognised and acknowledged the shortfalls in their oversight of the action plans and whether compliance had been actually been achieved. They have submitted new proposed management arrangements that acknowledge that the previous managers appointed have not been experienced managers and this has impacted on the provider's ability to move the service forward.

The proposals included the quality and improvement lead will be based at the home two days a week in the

short term and the operation director will visits to check and agree before any actions can be shown as completed.  This had started to be implemented. For example, the operations director and reviewed the infection control audit that had been completed and had set clear actions that were to be reviewed in one month.

The acting manager is also the registered manager for another of the provider's care homes in the locality. They had been based at the service for 20 hours a week for three weeks. The new proposed structure is the acting manager working 20 hours a week at Coral house, a full time supernumerary deputy manager, an administrator and two senior support workers. As part of the new structure there would be a shift leader who would co-ordinate and lead the shift. This is so people, professionals and relatives will know who is responsible for leading the shift each day. The operations director informed us they were currently recruiting to these posts. The operations director said all new staff would be trained in the provider's quality assurance and governance systems.

In addition, the provider has contacted the local authority service improvement team who have agreed to work in partnership with the acting manager to make the improvements required.

The acting manager had held a full staff meeting with a set agenda that included reviewing and learning from incidents and safeguarding investigations. Staff were also able to add to the agenda and had done so at the first meeting.

The acting manager had arranged for staff from the other care home they managed to come and work alongside staff so they could model a different ways of supporting and caring for people.

People told us they had regular 'Your Voice' house meetings. We saw where people had identified any actions these had been followed up.