Care UK Community Partnerships Ltd

Scarlet House

Inspection report

123 Westward Road
Ebley
Stroud
Gloucestershire
GL5 4SP

Tel: 01453769810
Website: www.careuk.com

Date of inspection visit:
13 November 2017
15 November 2017

Date of publication:
19 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Scarlet House on the 13 and 15 November 2017. Scarlet House provides accommodation, nursing and personal care to 86 older people and people living with dementia. It also provides short term respite for people as well as people who require rehabilitation support. At the time of our visit 80 people were using the service. Scarlet House is located near Stroud in Gloucestershire. The home is located closely to a range of amenities. This was an unannounced inspection.

We carried out this inspection following concerns raised to us by the provider and local authority safeguarding team regarding the quality of the service. We also reviewed information provided by the HM Coroner in relation to the service and an on-going inquest.

We last inspected the home on 14, 15 and 19 April 2016. At the April 2016 inspection we rated the service as "Good". We found the provider was meeting all of the requirements of the regulations at that time. At this inspection we rated the service 'Requires Improvement' overall.

A registered manager was not in position at the service, the registered manager had previously left the service and an interim manager had been appointed. They were planning to register with CQC until a permanent manger had been recruited. 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.

People did not always receive care which was personalised to their individual needs. Some staff did not yet have the confidence to follow up on people's well-being concerns and ensure people received the support of healthcare professionals. Opportunities had not always been taken by the service and staff to ensure people received care which ensured their wellbeing and cultural needs were met and maintained.

People and their relatives told us they or their relatives were safe living at the home and enjoyed the meals they received. Care and nursing staff treated people with dignity and ensured they had their nutritional needs met and received their medicines as prescribed. Catering and care staff were aware of and met people's individual dietary needs.

There were enough staff deployed to ensure people's needs were being met. Care staff were receiving the training they needed to meet people's needs. Staff spoke positively about the change in management and felt they were now receiving the support and communication they required.

Care staff were caring and were aware of people's health needs. Care staff treated people with dignity. People and their relatives felt their concerns and views were listened to and acted upon. Relatives told us they were informed of changes and felt the new management team was responsive and approachable.

The manager and provider had implemented system to monitor and improve the quality of service people received at Scarlet House. Progress was being made to improve the service however a range of actions identified by the provider and manager were still to be completed.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The risks associated with people's care were managed and people were supported to take positive risks. People received their medicines as prescribed.

There were enough staff deployed to meet the personal care needs of people. People felt safe living at the home and staff understood their responsibilities to report abuse.

Is the service effective?

Good

The service was effective.

Care staff had access to the training and support they needed to meet people's needs. However, the service had identified not all staff had received supervision or appraisals. The service was addressing these concerns.

People were supported to make day to day decisions around their care.

People received the nutritional support they needed. People were supported with their on-going healthcare needs, including rehabilitation to return to their own homes.

Is the service caring?

Good

The service was caring. Care staff knew people well and what was important to them.

People's dignity was promoted and care staff assisted them to ensure they were kept comfortable. People's independence and individuality were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's well-being needs were not always effectively acted upon to ensure people received the support of healthcare professionals.

Where people were at the end of their life they received support to keep them comfortable, in line with their wishes. However the support they received had not always been documented.

People and their relatives told us they felt involved and their concerns and complaints were listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not continually well led. A new management team were in place who were in the process of driving improvements to the service. Time was needed for the provider to complete their improvement plan and ensure people would always receive personalised care.

People and their relative's views were sought and they felt the registered manager was responsive to their concerns.

Staff felt the service was improving and they had the communication they needed to ensure people's needs were met.

Scarlet 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 was 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 inspection took place on 13 and 15 November 2017 and it was unannounced. The inspection team consisted of three inspectors, a specialist advisor and an expert by experience. The expert by experience's area of expertise was in caring for older people. At the time of the inspection there were 80 people living or receiving respite care at Scarlet House.

We did not request a Provider Information Return (PIR) prior to this inspection as we had brought the inspection forward due to concerns raised by the provider and local authority safeguarding. 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 reviewed the information we held about the service, including a provider action plan for Scarlet House. This included notifications about important events which the service is required to send us by law.

We spoke with 11 people who were using the service and three people's relative. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 19 staff members; including eight care staff, the chef, three nurses, a lifestyle co-ordinator, the deputy manager, the interim manager and 4 representatives of the provider. We reviewed 12 people's care files. We also reviewed staff training and recruitment records and records relating to the general management of the service.

Good

Is the service safe?

Our findings

People felt safe living at the home. Comments included: "We're well looked after"; "Yes, I feel safe there's always someone walking about"; "Oh yes we feel safe we don't worry about anyone breaking in (to the home)" and "I feel safe here and I've never come across a bad carer they have all been very good and nobody has been aggressive or shouted at me". Relatives told us they felt their loved ones were safe living at Scarlet House. Comments included: "Yes he's safe" and "I think the home is safe, I have no concerns." Information regarding safeguarding was available for people and their relatives to access on noticeboards within the home.

People were protected from the risk of abuse. Care staff had knowledge of types and signs of abuse, which included neglect. They understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to their line manager or the registered manager. One staff member said, "You can always go to the manager. The new manager is very open to concerns". Another staff member told us what they would do if they were unhappy with the manager's or provider's response. They said, "I know I can go to the adult helpdesk". Care and nursing staff told us they had received safeguarding training and the manager and provider were in the process of ensuring this training was refreshed.

The interim manager and provider raised and responded to any safeguarding concerns in accordance with local authority's safeguarding procedures. Since our last inspection the provider had ensured all concerns were reported to the local authority safeguarding team and CQC. The interim manager and provider worked with all staff employed at Scarlet House to ensure that lessons were learnt from any concerns and effective action taken to ensure people's safety. The service discussed incidents within the home and how they could learn from them to ensure care and nursing staff were up to date with people's changing risks and health care needs. We sat in on a daily heads of meeting called "11 at 11". During this meeting, incidents were discussed and information shared to ensure lessons were shared and implemented. The provider had also been concerned that staff may not feel confident to raise any safeguarding concerns so had reinforced the importance of reporting safeguarding concerns through additional training and supervision. Staff were supported to openly raise any concerns they may have about the service. One member of staff said, "(Staff) didn't feel able to raise concerns. (Manager) is different, responsive and approachable. She can tell you the outcome."

People could be assured the home was safe and secure. Safety checks of the premises were regularly carried out. People's electrical equipment had been checked and was safe to use. Fire safety checks were completed to ensure the service was safe. Fire exit routes were clear, which meant in the event of a fire people could be safely evacuated. Equipment to assist people with safe moving and handling were serviced and maintained to ensure they were fit for purpose.

People could be assured the home was clean and that housekeeping staff followed recognised safe practices in relation to infection control. The home was clean and there were no malodours within the home. People felt the home was clean. Care staff wore personal protective clothing when they assisted people with their personal care. Care staff told us how they protected people from the spread of infection.

Prior to the inspection a new head of housekeeping had been appointed who had recruited a full team of housekeeping staff and felt they had the support and resources they required to maintain the cleanliness of the home.

People had been assessed where staff had identified risks in relation to their health and well-being. These included moving and handling, mobility, agitation, nutrition and hydration. Risk assessments gave staff guidance which enabled them to help people to stay safe. Each person's care plan contained information on the support they needed to assist them to be safe. For example, one person had clear assessments in place for staff to follow to protect them from the risk of pressure damage and to assist them with their mobility. The person required support from care staff and the use of equipment to enable them to safely move around the home. The equipment the person required was clearly documented and including pressure relieving equipment as staff had identified they were at risk of pressure sores on their heels. Staff informed us and we observed they had the equipment they needed to meet this person's needs and to keep them safe.

People were supported to balance their personal wishes with their care and risk assessments. For example, one person enjoyed an occasional alcoholic beverage. The person's care plans stated that they could enjoy a drink however not at the same time as 'as required' medicines to aid sleeping. Care and nursing staff were aware of this and ensured when the person was receiving medicines to assist them with sleeping, that they were encouraged not to have an alcoholic drink. Records showed this had clearly been communicated to the person and they had been involved in this decision.

People and their relatives told us there were enough care staff deployed to meet their or their relatives needs and they were able to seek the attention of care staff when required. Comments included: "The staff are great, we can always have a good chat"; "I think there are enough staff, we have no concerns"; "Yes, I have a call bell and I use it and they come very quickly but not always in the mornings" and "We all have call bells in our rooms and when we use them they do come quickly".

The views of the staffing levels in the home from the care and nursing staff were mixed. Some shared with us they felt there were enough staff. Others felt on occasions there had not been enough familiar staff and the home had relied on agency staff to meet the needs of people, and these agency staff were not always familiar with people's needs. Comments included: "Staffing is now okay, it wasn't, we had low staffing levels in the afternoons. We do have time with the residents now"; "Staffing is quite good now"; "We sometimes have loads of agency staff at weekends"; "We have enough staff to cater for everyone's needs" and "It's stressful and a struggle when we're short staffed. Although we can meet people's physical needs, we never get time to sit and chat with residents or have a cup of tea with them".

We observed there were enough staff deployed to meet people's needs, however staff were not always organised on their units in a way which proactively engaged with people. For example, during the morning of one of our days of inspection, people enjoyed lively and friendly engagement from care, lifestyle co-ordinators and nursing staff. However in the afternoon, while staff were available, we observed they prioritised tasks such as completing records on computers based in communal areas, or cleaning/organising kitchen equipment. We discussed this concern with the interim manager and representatives of the provider, who informed us they were aware of the situation and were working with all staff to implement and develop leadership and delegation skills within units to ensure people had access to effective support and stimulation.

Records relating to the recruitment of new care staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring

checks (criminal record checks) to ensure staff were of good character. The provider operated an electronic recruitment process; once the process had been completed the interim manager would agree or decline to appoint the staff member. Where concerns had been identified during the recruitment process, the interim manager and administrator assured that these were discussed and risk assessments implemented to ensure staff were suitable and people remained safe.

People's prescribed medicines were kept secure. The temperature of areas where people's prescribed medicines were recorded and monitored to ensure people's medicines were kept as per manufacturer guidelines. Where people required controlled drugs (medicines which required certain management and control measures) were administered in accordance with the proper and safe management of medicines.

People received their medicines as prescribed. Nursing and care staff mostly kept an accurate record of when they had assisted people with their prescribed medicines. For example, staff signed to say when they had administered people's prescribed medicines and kept a record of prescribed medicine stocks and when they had opened people's prescribed medicines. The interim manager and provider told us they had identified that improvements were needed to ensure people's MARs would always be completed. They had implemented a monitoring sheet to reduce gaps and ensure the risk to people not receiving their medicines as prescribed were reduced. One nurse told us that this system had been beneficial and had led to there being no gaps on their units MARs.

We found people were receiving their medicines as prescribed. We counted people's prescribed medicines, against their MARs and other relevant records. People's stocks were all accounted for by care and nursing staff. Nursing and care staff understood their responsibility to raise concerns if they believed a person had not received their medicines as prescribed.

We observed one nurse and two care staff assisting people with their prescribed medicines. For example, one member of care staff assisted a person with their prescribed medicines in a kind and compassionate way. They clearly communicated what the medicines were for and asked if the person wanted to take them. They gave the person plenty of time and support to take their medicines. The person was in control throughout, offered choice by the staff member and given a drink with all their medicines.

Good

Is the service effective?

Our findings

People and their relatives felt the care and nursing staff were skilled and knew how to meet their daily needs. Comments included: "The staff are great"; "I like it here the staff are very good. The care is very good, and they know my needs"; "We can't fault it here the staff are good and caring and it's always nice and clean" and "The staff are so caring and kind and they know my needs."

Care and nursing staff told us they had access to the training they required to meet people's needs. Care staff told us they had recently been through a period of refreshment training which included training deemed as mandatory by the provider including safeguarding and moving & handling. One member of staff told us, "They really enforced the training; we're all trained to (providers) standards. It is much better and the training really helped." Other staff spoke positively about having the skills to meet people's needs. Comments included: "The training has given us the skills we need"; "Training is helping to improve the morale of staff" and "We get the time to develop our skills."

The provider had arranged for a training manager to attend to Scarlet House to address any training needs they had identified, or staff had identified. On the second day of our inspection, the training manager was visiting the service and assisting staff with their skills. The interim manager informed us it was important for all staff to undertake the same training and development. They explained this plan and level of support ensured all staff had the training and skills they required.

Care staff were supported to take on qualifications in health and social care. For example, one member of staff informed us they had been supported to complete a level 2 diploma in health and social care. They said, "I was supported to complete a qualification in health and social care. It was useful. I've got what I wanted."

Nursing staff felt they had the support and development they needed. Nurses told us they were supported to maintain their clinical skills and could seek support to develop their skills alongside healthcare professionals, such as, training around syringe drivers (for people who required medicines at the end of their life) and tissue viability.

While staff spoke positively about recent changes in the management of the service and the support they now received, however they openly told us they had not always felt supported in the past and had not always had access to an effective supervision and appraisal programme. Comments included: "I don't think I've always been supported. However, they are asking now and needs change"; "Staff haven't felt valued. There is a big difference now, we're feeling listened to"; "I feel they (management) listen to us now, we listen to them as well" and "I haven't had a supervision for over six months." The interim manager and provider were aware that staff had not had access to supervision (one to one meetings with their manager) or an effective annual appraisal system. They had started to implement a new system which would ensure that all staff would have access to the support they required. Staff were confident that they could go to a representative of the provider, or the interim manager if they required additional support.

Care and nursing staff had an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and knew to promote choice when supporting people. The 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care and nursing staff understood and respected people's rights to make a decision. Staff explained how they embedded the principles of the MCA into their practice. Comments included: "I always ask people before I do anything for them" and "We always provide choice. Throughout the day we offer people choices around their food, drink and what they like to do. We support people to continue making the decisions they can." At mealtimes we observed care and catering staff assisting people to make a choice of what they would like to eat. There were two options plated up so people could see and smell the meals which enabled them to make an informed decision. One person had clearly made up their mind on what meal they wanted, and had communicated this to staff, however they were still offered a choice. They told us, "I'm having the salmon. The staff always respect my choice."

People's mental capacity assessments to make significant decisions regarding their care at Scarlet House had been clearly documented. For example, one person was having their medicines administered covertly as they did not have the capacity to understand the risks to their wellbeing if they refused their prescribed medicines. Assessments had been carried out to see if these people could make a decision. The service worked with the person's family members, lasting power of attorneys and relevant healthcare professionals, including GPs to discuss the support they could provide in each person's best interests. The person's GP had identified the medicines which were to be administered covertly and how they should be administered. Care and nursing staff were aware of this information and it was clearly documented in the person's care records.

At the time of this inspection a number of people were being deprived of their liberty within the home. 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). The manager was aware of their responsibilities to ensure where people were being deprived of their liberties that an application would be made to the supervisory body. Where people were living under DoLS this was reflected in their care plans. Care plans also documented how staff should support people in the least restrictive manner. Where people were under constant supervision or equipment was in place to monitor people's safety and movements, such as sensor mats, this was included in DoLS assessments and relevant mental capacity assessments had been completed.

People's needs were assessed before moving to the service. Pre-assessments that were detailed and showed that people's physical and mental health needs had been assessed. Assessments included information in relation to people's nutritional needs and needs around their anxieties and mobility needs. The care plans provided staff with basic guidance on the person's dietary preferences and how they should be supported with day to day choices. Care staff told us that the care plans provided them information on people's health needs.

People's care plans reflected their diversity and protected characteristics under the Equality Act. People's sensory needs had been identified and staff were prompted to make sure people had access to equipment to ensure their continued independence. For example, checking hearing aids were in working order and glasses were accessible.

People had access to health and social care professionals. Records confirmed people had been referred to a

GP, continuing healthcare professionals, occupational therapists and physiotherapists. Additionally people were supported to attend appointments when required (such as when families were unable to escort their relatives to appointments). People's care records showed relevant health and social care professionals were involved with people's care. For example, one person had been referred to the dentist as they had expressed some pain with their teeth. There was a clear record of the appointment and the outcome, which included changing the person's toothpaste, which the service carried out.

Where people were at risk of choking or malnutrition, they had been provided with a diet which protected them from these risks such as soft meals and high calorie diets. Care staff knew which people needed this support. For example, one person was assessed as being at risk of choking and malnutrition. There was clear guidance in place for staff to support this person regarding their meals ensuring they were all soft and fortifying their food and drink to meet their nutritional needs. Care staff confidently discussed how they assisted this person to support them to maintain their health and wellbeing.

People and their relatives spoke positively about the food and drink they or their relatives received in the home. Comments included: "We don't get hungry at night, we have two cooked meals a day and if you don't want to eat in the dining room you can have your meals in your rooms"; "It's alright it's not super deluxe but it's very good and we get enough choice and I can eat everything, so I don't have a favourite meal and I never get hungry at night" and "I've eaten here yesterday and the food is very good." Care staff supported people to have access to food and drinks throughout the day. Fresh drinks were in communal areas which were distributed from special machines and people's rooms and were refreshed daily or more often if required. One relative told us, "(relative) is on pureed food and thickened drink and they do try to feed him still."

People received diets which met their dietary and cultural needs. For example, one person required a gluten free diet. The chef and care staff told and showed us that this person had specific meals to meet their dietary needs. The chef spoke positively about the facilities they had to ensure people had diets which met their health or wellbeing needs. They explained how they were informed of people's changing needs, such as weight loss and people's dietary needs at their assessment. The chef showed us how they ensured people had additional options at mealtimes. For example, whilst talking to the chef, they were asked to provide green beans for one person who required a soft diet. They explained to the care staff that this may not be possible, however they would try. The chef explained how they would fortify people's food if they had been assessed as being at risk of malnutrition.

People were comfortable in their environment. The home had handrails around the home which were in accordance with best practice guidance from the Royal Institute for the Blind to ensure people with visual impairments could navigate around the home. The home was nicely decorated with a range of communal spaces that people could enjoy with others and their visitors. We observed people enjoying the home's bistro, sun lounge and dining rooms. The suitability of the home's environment for people was discussed as part of their monthly review. Whilst this had not been consistently recorded the interim manager was aware of this and was taking effective action to ensure everyone's environmental needs were being reviewed and met to ensure people were able to independently orientate themselves around the service.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the caring nature of staff employed at Scarlet House. Comments included: "I love it here for my husband they are really kind and I would recommend it to everyone"; "The staff are so caring, it is who they are. I like them"; "We're really well looked after here" and "I wouldn't change anything I'm quite content here."

People enjoyed positive relationships with care, nursing and other staff. The atmosphere was often friendly, inviting and lively in the communal areas with staff engaging with people in a respectful manner. We observed many warm and friendly interactions. Staff encouraged people to spend their days as they wished, promoting choices and respecting people's wishes. For example, one person was supported to attend an activity in the lounge at their request. A member of staff supported and encouraged the person, and assisting them at their pace. They enjoyed a friendly and lively conversation as they headed to the lounge.

People engaged staff and were comfortable in their presence. They enjoyed friendly and humorous discussions between each other. People talked to each other and clearly respected each other and were observed talking and laughing with each other. Two people had formed a firm friendship in the home and they enjoyed talking with each other and staff before their lunch meal came. Another person enjoyed a friendly and lively conversation with two members of staff after the mornings activities had finished.

People were supported to maintain their personal relationships. For example, People and their relatives told us that visitors could visit at any time and there were no restrictions in the visiting times. One person said, "I have two boys and a girl, and they come and see me and if I need to make a decision it will be done by my children and them doesn't seem to be any restrictions to when they can come and go." The service worked with people's families to ensure they were involved in any changes and were comfortable in the home. One relative told us, "I can visit anytime, we are made to feel welcome and there are a few nice areas we can sit and chat."

People's dignity was respected by care staff. For example, when people were assisted with their personal care staff ensured this was carried out in private. People living at Scarlet House felt they were treated with dignity and respect and their wishes were respected. We received comments such as: "They always knock on my door and they always close the curtains and the door if there doing anything for me"; "I shower as often as I can and yes I need someone on standby and I don't care if its male or female carer" and "We have a shower in our rooms, but we can have a bath and the carers help us and we can have one every day."

Care and nursing staff told us how they ensured people's dignity was respected. All staff members told us they would always ensure people received personal care in private and would ensure they were never exposed. Comments included: "We treat everyone as individuals and respect their individuality and the things that are important to them. We make sure people are presented the way they would like to be. The way they always have been" and "I treat the residents as I would treat my own mother. We always give 100% to residents and make sure they are comfortable." One person's relatives praised the care staff for the way they assisted their relative with their personal grooming needs and said, "Up until the last few days he would

have a shower every day but now he has a bed bath every day and the staff shave him."

People were able to personalise their bedrooms. For example, people had decorations or items in their bedroom which were important to them or showed their interests. For example, one person's room contained photos of their family and people who were important to them. Another person had a number of possessions they had brought from their own home, when asked they spoke positively about their room and felt it was their "space."

People where possible were supported to make decisions around their care and treatment. For example, one person's care plan clearly documented their views and also their wants and wishes regarding their end of life care. This person had also made a decision to refuse resuscitation in the event of cardiac arrest. This decision was clearly recorded in the person's care plans. Other people had completed advanced care plans which documented how they wished to spend their final days and what things were important for them to have at the end of their life, such as family and specific music. Additionally one person had clearly documented who they wished to be involved in their care and how information should be provided to them; this provided the person with comfort knowing that their information would not be shared without their permission.

Requires Improvement

Is the service responsive?

Our findings

People may not always benefit from personalised care which is tailored to their individual needs. We found staff had identified people's needs and health concerns. However, they had not always followed up on going concerns or when referrals for specialist advice had been made to ensure people's health and wellbeing needs were met. Staff had not always considered what action they needed to take in the interim. This meant people's needs were not always supported whilst staff waited for specialist health professional's input. For example, during our inspection, one person was calling out and was in discomfort. A nurse informed us the person had toothache. The person had had toothache for three days. Staff had called the person's GP who had advised to give the person regular paracetamol. While staff had taken initial actions when the person presented with pain, they did not follow this up, repeat or reinforce their concerns to outside healthcare professionals to ensure prompt pain relief. During our inspection, the service sought further advice and stronger pain relief medicines had been prescribed for the person.

Staff did not effectively explore all options to meet people's individual wellbeing needs. For example, one person's nutritional care plan identified they had been steadily losing weight over a six month period. When asked, nurses informed us they had informed the person's GP and arranged for a Speech and Language Therapy to assess the person's swallowing which was still pending. The person's relative expressed their view that their relative needed a different diet as they were finding it difficult to chew. We discussed these concerns with a member of care staff who ordered a pureed lunch for the person. The person went on to eat and enjoy their lunch.

People's diverse and cultural needs were not always known and supported by staff. People's care plans did not always document people's social needs and preferences. For example, one person had a specific cultural belief. We asked two members of care staff how this person was supported with their cultural needs and if they knew what their cultural needs were. One member of staff explained, "I'm not sure, she has no wishes to follow her religion here." There was no information in the person's care plan regarding their involvement in their cultural beliefs or any exploration of supporting the person to continue to follow their beliefs or reminisce about them. We discussed this concern with the interim manager and provider who informed us they would look into these areas.

People's relatives were informed of any changes in their relative's needs. For example, one person's relative told us staff always kept them updated and informed of their relative's needs and wellbeing. They said, "I am told if there has been anything of concern. They do keep me updated." People's care records showed where staff had contacted family members to ensure they were updated on their relative's well beings. People's relatives and representatives were also informed of or attended "resident of the day" assessments which focused on and reviewed people's needs whilst living at Scarlet House. However, there was nothing noted within the care plans to indicate that people or their advocates had been involved in the care planning process or the review process. Despite this, staff did know people's needs, although they said this was down to "experience".

People's preferences in relation to their end of life care had not always been documented. One person had

moved to the service 15 months ago, but it was documented in their end of life plan "This is just an initial plan; more detail to be added". No further detail had been added and it was unclear whether staff had tried to have discussions with the person and their family about their wishes for their end of life care although staff were now assisting with palliative care.

There was not always clear guidance in place for care staff to assist them meeting the needs of people who were anxious or agitated. For example, care staff told us about four people who could become agitated and resistive to personal care, or exhibit behaviours which may challenge. Staff told us how they reassured and assisted these people, for example taking time to sit with them or going with them for a walk in the home's garden. However there was no recorded guidance on how staff should assist them. One member of staff told us about how they assisted one person and said, "It's the way you approach. You have to encourage." This meant that staff may not always have a consistent approach to assist people when they become agitated.

Staff had documented the occasions when people had displayed anxieties or behaviours which may challenge as far back as August 2017 however there was no plan in place to inform staff how to meet these people's needs. For example, one person's communication plans guided staff to maintain eye contact and to speak slowly and clearly however made no reference to the behaviour the person displayed when distressed or agitated, such as calling out and how staff should support them. People may not always receive personalised care as information about how to support people who became agitated or upset was not available to staff who were unfamiliar with their needs.

People's mental capacity to consent to the use of bed rails had had been clearly assessed. However, staff had not always documented how the decision had been reached and had not always documented whether less restrictive options had been considered such as when bed rails were being used. Additionally, one person's lasting power of attorney had been involved in a best interest decision in relation to their relatives care, however there was no recorded evidence their views had been taken into consideration as part of this process.

People did not always benefit from person centred care which proactively met their health and wellbeing needs. These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we also heard examples of staff responding promptly and effectively to people's changing needs. For example, staff had identified swiftly when one person's health deteriorated and realised that they were nearing the end of their life. One staff member told us ''The person stopped eating, slept a lot, had more pain and found it difficult to eat''. Staff had immediately contacted their GP and ensured the prescribed pain medicines were in stock in case the person's health was to further deteriorate over the weekend. They also informed the cook to prepare a soft meal for the person to reduce their risk of choking whilst they awaited a Speech and Language swallowing assessment. Their relative told us "Yes, the GP comes into see my husband on a regular basis due to my husband being on Morphine now because of the pain in his legs" "The care here is second to none overall and yes they do know he's needs and the staff say that he's their favourite resident"

People enjoyed activities and stimulation which was appropriate to their needs and age. For example, the "memory man" entertainer visited the home weekly and provided a lively and active session which included quick fire quizzes and singing which people really enjoyed. Two people prior to the activity told us how much they enjoyed it. One person said, "I'm off to see the memory man, it's great." Care and life style co-ordinator staff assisted people who required some help to enjoy the activity to their fullest.

The home employed a team of lifestyle co-ordinators who developed a plan of activities for people living at Scarlet House. We spoke to a member of the team who told us, "We have a program of activities and there are four full time activities coordinators. I like to interact with the residents and my thing is exercising and the lead coordinator lets me get on with it. One of the reasons is that when I was at (previous home) I trained with the physiotherapist and that's been good for the residents here and I do one on ones and I get to sit and talk to people on end of life."

People spoke positively about the activities within the home and the impact it had on their life, they spoke fondly of the exercise activities and how these kept them engaged. Comments included: "This morning we had memory man come in and he's so good there's lots of activities to do if we want and we can go out but that's with a carer into the garden"; "I enjoy the activities" and "I think there is enough to do and you can change your scenery."

People knew how to make a complaint if they were unhappy with the service being provided. One person said, "I have never had to complain." The interim manager kept a record of complaints and compliments they had received about the service. They had clearly investigated these complaints and discussed the outcomes with people and their relatives. For example, one person complained about the care of their relative, the interim manager documented the action they had taken to deal with the complaint to ensure concerns weren't repeated.

Requires Improvement

Is the service well-led?

Our findings

We carried out this inspection following concerns identified and raised to us by the provider, as well as an ongoing HM Coroner's Inquest. A number of shortfalls we had identified at this inspection had been identified by the provider. They had ensured a structured management support team was in place and were following an improvement plan which had prioritised actions to reduce potential risks to people's health and to drive the quality of the service to a standard the provider expected. While the provider had identified concerns prior to inspection, actions at this time were still ongoing and had not been fully implemented and evaluated to ensure people would always receive effective personalised care. Therefore we have rated this question as 'Requires Improvement'.

This had included ensuring all staff had training and support in relation to safeguarding of vulnerable adults and received training in areas that had been identified. Current actions documented in the provider's service improvement plan related to communication and audits within the home. This was an area the interim manager was addressing through daily heads of meeting discussions. Prior to our inspection, the provider had submitted their service improvement plan to CQC to advise us of the progress they were making.

The interim manager had a clear focus on their responsibilities and goals for Scarlet House. They explained that they were going to apply to CQC to become the registered manager of Scarlet House. 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. They discussed the providers plan to recruit a new permanent manager for the service who would take over from the interim manager. A comprehensive handover and induction programme would take place to ensure the new manager was familiar with the management and running of the home, enabling them to get to know the service, the people who lived there and staff. The interim manager spoke positively about the action that had already been taken to improve the service and the continued progress.

Nursing and care staff spoke positively about the management changes and felt they now received the communication and support they needed under the interim manager. One nurse told us, "We get a lot of support now. I'm proud of the home and we get good feedback from relatives". A member of care staff said, "Things have improved, when changes are made they are explained to us. We are involved in discussions and the manager listens to our ideas, and lets us run with them if they are useful". The interim manager arranged daily meetings where they spoke to heads of teams to ensure information was shared around the home and to ensure that all staff had the direction and guidance they required. Staff found these meetings useful, with one member of staff saying, "It enables us to share information and good practice. Makes you think about things from a different perspective".

People and their relatives spoke positively about the management of the service. Comments included: "I don't know the new one (manager), but I think they are doing a good job and the staff seem to be doing new things to entertain the residents"; "I do think they're doing a good job" and "It's well organised here and they are doing a good job."

People and their relative's views on the service had been sought and these views were being acted upon. A survey was carried out by the provider every three months. The results of the May to August 2017 audit showed strengths around activities and communal facilities however they had identified that actions were needed around hygiene within the service and the availability of staff. These actions had been added to the service's service improvement plan and responses had been provided to people and their relatives through a report published by the provider.

The provider operated a self-audit schedule. This ran through an annual system of audits around health and safety, infection control, management of medicines, documents, nutrition, and dementia care and tissue viability. A documented audit in November 2017 had identified shortfalls in people's pre admission and admission records as well as records relating to their consent to care. The service was taking action to rectify these shortfalls. All actions were included in the service improvement plan to aid the development of the service.

In September 2017 the provider had also carried out a full 'regulation governance review' of Scarlet House. During this review they identified concerns around the storage of medicines and issues around people's care records not always being personalised. The management team had taken immediate action to ensure people's prescribed medicines were stored safely. There were ongoing plans in place to ensure people's care records were personalised to their needs, this included using the resident of the day scheme to identify people's personal needs and preferences and lead to improvements to the service. Improvements were also being made to ensure people's MARs would always be completed and staff had recently received additional training to support them to complete people's turning and fluid charts.

The service acted on professional guidance and support from healthcare professionals. For example, the pharmacy contracted to supply people's prescribed medicines carried out an annual review on the management of people's medicines. At their last review they had identified issues in relation to 'as required' protocols. The provider had taken action in relation to these comments to ensure the risk to people was reduced.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care which was personalised to their needs and wellbeing. People's consent to their care had not always been assessed or documented. Regulation 9 (1)(a)(b)(c) 3(a)(b)(c)(d).