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Marine View Rest Home

Inspection report

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Date of inspection visit:
30 November 2017

Date of publication:
10 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 30 November 2017, and was unannounced

Marine View Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can provide accommodation and personal care for 19 people in two linked buildings that are adapted for the current use. The home provides support for people living with complex needs and additional support needs in relation to mobility and sensory needs. There were 14 people living at the home at the time of our inspection.

The home had a manager who was also the registered provider. A registered provider is a person who has registered with the Care Quality Commission to manage the home. Like registered managers, 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 home is run.

At the last inspection on the 5 April 2016 the home was rated as 'Requires Improvement'. We asked the provider to make improvements in relation to gaining sufficient feedback about the service from people and their relatives, identifying risks associated with people self-administering their medicines and ensuring people's changing needs were suitably recorded and reflected in care plans. This report discusses our findings.

At this inspection improvements had been made in some areas. The provider had established and gained sufficient feedback from people and their relatives to inform improvements in the home. There were systems in place, including annual feedback surveys and meetings that ensured people and their relatives views were regularly encouraged and used to improve the home. Overall people and their relatives were positive about the home and told us they felt listened to by the provider. However, further areas of improvement were identified, including four breaches of regulation in relation to providing personalised care, safe care and treatment, good governance of quality assurance and health and safety and complying with the requirement to suitably display the homes Care Quality Commission's (CQC) performance rating. This is the second consecutive time the service has been rated 'Requires Improvement'.

Records and assessments were not consistently reviewed or used to inform staff fully of people's needs, mitigate risks to people's wellbeing and safety. The registered provider and staff acknowledged that people's initial placement assessments, risk assessments and care plans were not detailed enough fully guide staff on how to meet people's needs and make manage any impact this may have on others living at the home. Care plans were not personalised enough to reflect people's emotional needs, for example in relation to progressive health conditions or bereavement. Accident reporting was not sufficiently investigated or personalised in relation to outcomes and actions.

Practice around the safe administration of medicines was not consistently safe. Staff were trained and knowledgeable about people's medicines, and ensured they were given in a respectful and timely manner. However, there was a lack of guidance on how 'as required' and 'self-administered' medicines should be given. Self-administered medicines were not consistently risk assessed to ensure risks to people and others, were assessed, managed and mitigated. Practice around quality assurance and the home's governance was not always sufficiently robust in managing individual risk.

People and their relatives told us that staff were skilled and knew how to support them. Staff felt well supported by the registered provider and external trainer and consultant through supervision and essential training. However, staff also told us that they did not always feel they had sufficient training or experience to support people with more complex needs, for example people with progressive health conditions.

Mental Capacity Act 2005 (MCA) assessments were not always completed to ensure people's capacity was suitably assessed when making decisions that could put them at risk of harm. Staff had a good understanding of how they should work in line with the principles of the MCA. People were supported to have maximum choice and control in their lives. The provider was meeting the requirements of the Deprivation of Liberties requirements.

The registered provider completed environmental risk assessments and a programme of regular health and safety checks to ensure quality was measured and maintained. We observed audit activity for areas including, fire safety, food hygiene and infection control.

People and their relatives felt the home was safe and that they were treated with dignity and respect. People could tell us why they felt safe and protected from the risk of abuse. Staff could tell us about different types of abuse and how they should report it. Staff told us the home had zero tolerance to abuse.

People and their relatives told us they enjoyed the food and the warmth of the home. People's nutritional needs were met and they told us they had choice of food and drinks. People's rights and privacy were respected.

People and relatives told us there were suitable levels of skilled staff available to meet people's needs safely. Staff were supportive of people's right to take positive risks and make decisions. The registered provider and staff acknowledged they were working additional hours as the deputy manager had been absent for two months. Recruitment of two new staff had taken place in response to this and the home was still providing staff cover in line with its dependency tool. A dependency tool is an evidenced based approach, that assesses the needs of the people being supported and the level of staffing required. The provider had safe recruitment procedures in place to ensure people were supported by caring and responsible staff.

We found breaches 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 the 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?

Requires Improvement

The service was not consistently safe.

Care plans and risk assessments were not consistently reviewed to protect people from risk of avoidable harm or reflective of their changing needs.

People's medicines were not always managed and administered safely.

People felt safe and were protected from the risk of abuse by staff that were trained and understood different types of abuse and how they should report it.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Care plans were not personalised enough to reflect people's emotional needs, for example in relation to progressive health conditions or bereavement.

Staff did not always feel they had sufficient training or experience to support people with more complex needs.

Peoples' nutritional needs were met and they enjoyed the food and many choices of food made available

Is the service caring?

Good

The service was caring.

People and relatives told us the staff were caring, kind and attentive.

People's communication needs were promoted by staff that knew people well and listened carefully. People were happy and comfortable when spending time with staff.

People were involved in decisions that affected their lives and could access their communities.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people had a lot of control over what they did and had good access to their local community and interests. Some people and their relatives told us they would like more activities and stimulation in the home.

Care records and plans did not give enough detail and guidance to staff to ensure people had personalised and consistent care.

People and their relatives could make a complaint and told us that they believed their concerns would be taken seriously by the registered provider.

People received dignified end of life care.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality assurance and governance systems did not always ensure that care plans and risk assessments were reviewed or used to mitigate risks to people's wellbeing and safety when their needs changed.

The provider was not fully aware of their responsibility to comply with the CQC registration requirements as they had not displayed their most recent performance rating.

Feedback was gained from people and their relatives through residents meetings and annual surveys.

Marine View Rest Home

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 checked 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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on the 30 November 2017 and was unannounced. The inspection was carried out by one inspector, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Before the inspection we checked the information that we held about the home and the provider. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. This included previous inspection ratings and statutory notifications sent to us by the registered manager that tell us about incidents and events that had occurred at the home. A notification is information about important events the home is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we observed care and support in the communal spaces and people's rooms. We read five people's care records and six medicine administration records. We care pathway tracked people living at the home. This was so we could look at people's care planning in depth and match this with their experiences and our observations. We also read other records which related to the management of the home such as staff files, training records, policies and procedures and quality assurance information. We spoke with nine people who use the home, two care staff, one cook and the registered provider and observed how people were supported during the day and with their meals. Subsequent to the inspection we contacted and spoke with three relatives, two health professionals and one local authority quality team so that we could further understand their experiences and those of people who could not talk with us. We have included their feedback in the main body of the report.

The last inspection of the home was 5 April 2016 where we found areas of practice that needed to improve. The home was rated 'Requires Improvement'.

Requires Improvement

Is the service safe?

Our findings

People, relatives and staff told us that they felt the home was safe. One person said, "No problem, I am safe, staff are available". Another told us, "Yes I feel safe because it is secure, I don't feel frightened". A relative told us, "It is as safe, as far as possible, my relative is capable of making decisions and they enjoy going out." One staff member told us, "People are safe, they are independent we reinforce what they need to do when they go out and they all have cards with the homes name of them". However, although people and relatives gave positive feedback about their safety we found areas of practice in need of improvement.

At the April 2016 inspection people were not always protected from potential areas of risk. This was because the provider had not fully risk assessed the use of bedrails for one person to ensure this was the least restrictive option for them, or the self-administration of medicines by another person to ensure measures were in place to support their and others safety at the home. The provider was unable to demonstrate that one person's air mattress was suitably monitored to ensure that the risk of pressure damage to the skin was managed safely. We identified these as areas of practice that needed improvement. At this inspection we were unable to observe practice around the use of bedrails or air mattresses as they were no longer in need. However, we did observe how other individual risks were managed and found areas of practice that still needed to improve.

People were not always fully protected from the potential risk of harm as incidents involving people were not always investigated. Staff completed incident reports following accidents. Accident and incident records dated between January 2017 and October 2017 detailed that there had been seven incidents including four incidents relating to falls on the stairs. However, although they noted the cause and initial support given they did not consistently identify what actions were taken in response to reduce the risk of a reoccurrence. The registered provider noted several falls had taken place on the stairs and replaced the carpet 'to a less heavily patterned' design, however other factors including the narrowed space due to the presence of a stair lift and people's reducing mobility were not considered. Other records noted a burn from a hot drink and police being advised of significant concerns about one person's road safety awareness. But these did not detail what follow on action had taken place to ensure each person's wellbeing, or that their risk assessments had been reviewed to mitigate the risk of a reoccurrence. Risk assessments were not always reviewed and care plans updated.

The provider failed to adequately assess risk at admissions and as people's needs changed. Care plans and risk assessments discussed people's practical needs but did not always identify areas of risk to the person or others living in the home. For example, two people had significant progressive health conditions that reduced their mobility and for one person led to greater isolation. Risk assessments noted a higher risk of falling and advised that walking aids may be needed in the future but lacked guidance for staff on the people's health conditions, their fluctuating nature and how to support the person's changing physical and emotional needs. Risks associated with one person's conduct had not been assessed or identified during the initial placement needs assessment. The registered provider confirmed that they had some initial verbal assurances provided by mental health professionals in relation to the safety of others. However, these assurances were not documented and the care plan did not demonstrate the service was safely able to meet

the needs of the individual or mitigate risk in relation to the person, staff or other people living at the home.

People's medicines were not always managed safely. Medicines administration records (MAR) sheets noted that daily medicines were being given and signed for. However there were no 'as required' records for people requiring medicines that were not for daily use detailing the purpose of the treatment, the frequency of administration and the desired effects. Staff told us that there was no guidance available for medicines being taken where the pharmacy label stated 'use as described'. For example, medicines prescribed to temporarily manage pain, skin conditions or stomach discomfort. There was a lack of guidance available to staff that could ensure people received their medicines as the prescriber had intended. This demonstrated that people did not always receive their medicines as prescribed.

The home demonstrated some areas of consistent practice in managing medicines. Staff were trained and knowledgeable about peoples' medicines and we observed medicines were offered respectfully and that staff ensured time critical medicines were given in a timely manner. The medicines policy was current and included guidance on self -administering medicines. However, people who self-administered medicines were not always supported to do so safely. Four people self-administering prescribed medicines including an inhaler, eye drops and emollient did not have self-administration risk assessments in place and staff and medicines records confirmed this. The National Institute for Health and Care Excellence – Managing Medicines in Care Homes, states, 'An individual risk assessment should be completed to find out how much support a resident needs to carry on looking after their medicines themselves.' It advises that risk assessments should include the person's choice, if self- administering poses a risk to the person or others, if the person has mental capacity and the dexterity to take their medicines, how the medicines will be stored and how often the risk assessments need to be reviewed. Risk assessments were not always in place for people and this demonstrated that the provider had not made the improvements needed and has continued to not take sufficient measures to ensure peoples safety when taking their medicines.

The failure to assess, record and mitigate risks and provide safe administration of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Environmental risk assessments, audits, and a programme of regular health and safety checks ensured measures were identified to minimise environmental risk. The registered provider had oversight of health and safety through audits and checks of fire safety, LOLER, COSHH, Legionella, and gas safety and food hygiene compliance checks and emergency plans. Staff had training and procedures in place to inform their practice in relation to infection control and food hygiene. PPE (personal protective equipment) was used when required including aprons and gloves when preparing food and medicines. Individual personal emergency evacuation plans (PEEP), demonstrated that people's individual ability to evacuate the building in the event of a fire had been considered and planned for. Staff demonstrated awareness that people had the right to take risks. One staff member told us, "Just because someone lives in a care home does not mean that they can't go out and about. In fact we encourage it so people keep as independent as they can".

Staff were aware of their responsibilities in relation to safeguarding and whistleblowing to ensure people were safe. They had access to safeguarding training and policies that gave guidance on what to do if they suspected abuse, and were confident concerns would be taken seriously. One staff member told us, "I would not hesitate to go to the registered provider; there is zero tolerance for that sort of thing here". People were also informed about how they could remain safe one person told us, "I have the number of social services, my key worker is very good, I can talk to them openly".

People, relatives and staff felt that there was enough staff on duty to safely meet the practical needs of people. One person told us, "Yeah staff are very punctual;" another "Call the bell and staff are available when

needed". The home had a dependency rating tool that informed how many staff were needed and this was reflected in the rota. Staff rotas demonstrated that staffing levels were consistent and provided by permanent staff including care staff, night staff, a cook and a cleaner on a fixed pattern of shifts. During the inspection the registered provider was very active, supporting two care staff and a cook. The registered provider told us that the deputy manager had been absent for two months and that they were covering the care shifts which meant they were consistently working seven day weeks. Staff also told us that they were picking up extra hours to ensure shifts were covered. The registered provider acknowledged that this was not sustainable and advised us that they were currently in the process of recruiting two new staff.

Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks were completed prior to staff starting work which included Disclosure and Barring Service (DBS) checks, previous work history, and detailed application forms, proof of identity, interview records and appropriate references. The DBS is a national agency that keeps records of criminal convictions, DBS checks are completed for all staff working at the home to ensure they were suitable to work with people or children.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that the care given was good and that their support needs and preferences were known by staff. One person told us, "The people that work here are nice they look after me and give me what I want. When I am not well they tell the doctor and they help me to get better". Relatives felt confident that staff knew how to meet the practical needs of their relatives. One relative told us, "I don't know about the training the staff get, but they cope with my relative very well, they understand them better than I do". Although people and relatives gave positive feedback, we identified areas of practice in need of improvement.

People did not always receive care that was designed to meet their needs. Some people living at Marine View Rest Home had complex needs and health conditions that could challenge their independence and present a risk to them and others. The registered provider told us that initial assessments were undertaken prior to people moving into the home and care plans produced around these needs. However, they were not able to provide some people's initial needs assessment and not all care plans gave fully informed descriptions of how the staff were able to suitably manage peoples holistic needs; including physical, psychological, social needs and associated risks. For example, one person had a mental health diagnosis and was being supported by mental health professionals and the probation service. Staff were not fully aware of the circumstances of the placement or the full range of the persons needs and associated risk in relation to their mental health needs and the probation service involvement. For example, there was no guidance on how the person may present if they were experiencing deterioration in their psychological wellbeing. The care plan did not ensure that all their individual needs were communicated to staff and that risks to themselves and that may have impacted on others health and wellbeing were suitably minimised.

Training, supervisions and appraisals were delivered by an external provider. The registered provider's Provider Information Return (PIR) stated that supervision meetings were carried out by an external consultant, and that the registered provider believed this worked well as any concerns could be fed back to them formally whilst ensuring staff could do so without identifying themselves. One staff member told us that they had an opportunity to meet with the external consultant every three months and they felt well supported by the registered provider and were able to talk with them when they needed to. Essential training was documented to ensure training had been completed and was planned for. Staff told us they received training in topics such as Mental Capacity Act 2005(MCA), moving and handling, dementia, medicines administration and safeguarding and had National Vocational Qualifications (NVQ). One staff member told us, "I learnt a lot about different ways people behave, and improved my understanding of mental health conditions. I learnt that just talking to people can help to understand the underlying cause of the problem". New staff had inductions and access to the Care Certificate. The Care Certificate is a set of standards that social care and health workers should work in accordance with.

However, training provided was not always responsive to the needs of people. Staff told us that they were supporting a wider range of people with more challenging needs, including Parkinson's disease, Huntington's disease and substance misuse issues. One staff member told us, "I don't always feel equipped, or have the experience to know how to care for all the different kinds of people who now live here". Staff had

not received formal training in these areas, but told us they had done some self-directed research, that had informed their practice. This demonstrated that the registered provider did not consistently ensure that staff were being suitably trained and supported to effectively meet the complex needs and health conditions of recent placements.

The failure to ensure that staff were fully trained and informed of how they could meet the person's needs and make provision for any impact this may have on other people using the service was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA. People living at the home all had capacity to make decisions. People told us they were free to come and go and were always asked for their consent when staff supported them. One relative told us, "We are happy where our relative is, because of the freedom". People told us that they were able to make decisions and that their rights were respected. Staff had a good understanding of the MCA and the importance of enabling people to make decisions. Staff including the cook had knowledge and understanding of the Mental Capacity Act (MCA) and had received training in this area. However, where people had the potential through their progressive health conditions to experience, higher levels of risk or fluctuations in capacity this had not been assessed. There were no MCA assessments or best interest assessments available within care plans. For example, one person regularly refused to attend health appointments when their wellbeing was causing staff concern and refused medicines for their condition. There were no assessments or guidance in place to confirm their capacity, when making specific decisions about medical treatment or taking risks that could result in harm. This is an area that needs to improve.

People received regular support from healthcare professionals. People, their relatives and staff confirmed that health professionals such as GP's, dieticians and speech and language therapists were liaised with regularly to support and promote people to maintain good physical health. One relative told us that although their relative made decisions to not always engage with the doctor or take medicines that, "Staff do their best in terms of health. The registered provider got my relative to visit the GP recently which is an achievement".

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. No applications had been sent to the local authority. We found the registered provider understood when an application should be made and the process of submitting one.

People's nutritional and dietary needs were met. We spoke with the cook who had worked at the home for many years and knew people's nutritional requirements, and likes and dislikes. They told us that people could choose what they wanted on the menu, "Last night, they wanted the curry hotter, so we went from a korma, to a tikka masala, to madras, all within 30 minutes". One person had a condition that caused them to burn calories quickly and required a diet that was high in calories, easy to digest and nutritionally balanced. There was clear guidance available to inform staff of the person's dietary needs and records of menus and meals were kept. People's weights were recorded regularly to identify if they were malnourished or at risk of malnutrition (under nutrition). There were several meal choices made available to people, and they could

choose to eat in their room, or to have a meal put aside for them if they were going out. People were happy with the quantity and choice of food available, one person was heard to say, "That bacon pie is nice". The mealtime created a social environment with humour being shared each other and the cook.

People lived in an environment that had been adapted to meet people's needs. Due to the layout of the building the provider at times had to compromise some spaces to create others. For example, a large chest freezer was moved into the dining area to create a wet room on the ground floor, for a person with decreased mobility. People, relatives, staff and health professionals told us that the building was, 'tired' and in need of 'modernising' in places. However, they also told us that the living environment was 'relaxed', comfortable and a 'home from home'. People who used mobility aids such as walking sticks had access to communal spaces and a small outdoor space. People if required had access to a stair lift a walk in shower and grab handrails. People told us they enjoyed spending time in the community with easy access to seafront walks and local shops.

Good

Is the service caring?

Our findings

People were cared for by kind and caring staff. Throughout the inspection people and their relatives were positive about the care provided. One person told us, "Staff are very caring, always ready to help". Another person told us, "It can be hard living in place like this when you are used to living on your own but they do understand and do the best they can." One relative had written feedback that said, "The staff are very caring and attentive," another told us, "It was the caring nature of the home that helped me decide on the placement, even though the décor was uninspiring".

People told us staff respected their privacy and dignity. One person told us, "Yes in my room, they close the door when they do my personal care". Another told us, "Yes, staff knock before opening the door". Care plans and associated documents were stored securely in locked cabinets .The home had CCTV in place to promote the security of the home. The registered provider confirmed this was used for security only, only related to the outside of the building, and was not recorded. Notices were displayed reminding people of their privacy rights whilst CCTV in use.

People were relaxed and comfortable throughout the day, initiating and receiving conversation and humour with staff and each other. There was a friendly and comfortable atmosphere in the communal spaces of the home. People spoke with staff and each other and were equally as relaxed with the cook as they were the registered provider. People's communication needs were promoted by staff that knew people well and listened carefully. One relative told us that their relative's speech was becoming harder to understand due to a progressive health condition. They told us, "Staff can explain what my relative means, I need to use emails, but they are familiar with their use of language and help our conversations". Staff told us how one person used social media to stay in touch with their family, and enjoyed seeing pictures of their family.

People told us they were involved in decisions that affected their lives. Observations and records confirmed where possible people were able to express their needs and preferences in their care. People received support to maintain relationships that mattered to them. Relatives told us they visited the home regularly and were always welcomed. They told us they were involved in initial assessments and reviews of their relatives care, where they had the right to be included. They were complimentary about the ongoing care and support of people noting that they were regularly informed about changes in people's health or wellbeing. The registered provider also acknowledged in the Provider Information Return (PIR) that where people did not have relative's involved and required additional support to express their views in relation to care they would have access an advocate. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

People were encouraged to be independent. People told us that they were able to go out when they wanted to. One person told us, "After breakfast, I go out and do my errands, go to the library and go around shops". Another told us, "I am 100% independent, I go out by myself". Staff had a good understanding of the importance of promoting independence and told us that while promoting independence, they would also reinforce the importance of personal safety. For example, they would ensure they had contact cards, mobile phones and used a taxi when out late. People told us that staff were there if they needed assistance but that

they were encouraged and able to continue to do things for themselves. Where people required assistance staff took care to ask permission before intervening and assisting. Where assistance was declined, staff respected the person's wishes. Some people did not always choose to or were able to access communal spaces and their local community independently. One person told us they chose to spend more time in their room as they did not feel due to their gender and life experiences that they had much in common with the other people. We spoke with staff about how they prevented this person becoming socially isolated. They recognised this and told us that they 'popped in' to see the person and made sure they access to the things they enjoyed.

Staff told us and demonstrated that they had a good knowledge of people's individual needs, backgrounds and likes and dislikes. For example, one staff member demonstrated a good knowledge of one person's preferences and needs including their important relationships and mental health needs. They told us, "I notice when they are getting anxious, and can usually distract them". Staff spoke respectfully and with compassion about people and their needs, "They have good and bad days, like we all do". One health care professional who visited the home told us that staff were always friendly to the person they visited and that they appeared comfortable and relaxed. A relative told us, "My relative can be eager to have things, their own way; staff always are respectful and manage this without being abrupt".

Peoples' differences were respected and promoted within their day to day lives and care planning. People were able to maintain their identity; they wore clothes of their choice and could choose how they spent their time. Diversity was respected with regard to people's religion and care plans, diet and activities they were given access to demonstrate this. For example, one person was supported to access 'holy communion' at home. Another person's religious beliefs were respected and they were provided with an alternate meal that did not contain bacon. One person took longer to eat their meal as they struggled with holding a fork. Staff confirmed that they had been offered adapted cutlery, but had chosen not to use it, as they didn't want to be treated differently. We were able to look at all areas of the home, including being invited into people's own bedrooms. Bedrooms held items of furniture and possessions that the person had before they entered the home and there were personal items and photos on display. One person told us, "Have you seen my room? It's got all my guitars in it". People were supported to live their life in the way they wanted to and told us they believed their right to be different was respected. One person told us, "Yeah, very much so" I can be different.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they felt listened to by staff and involved in the regular decisions and choices about their care and support needs. We observed and people told us, that people, relatives, health and social care professionals were involved in developing initial care plans. People were very passionate about their independence and told us that they could make choices about how they spent their days. One person told us, "During the day I am at work, when I come back, I go out visit my friends and walk around the beach". A relative who spoke positively about the freedom and safety the home gave their relative told us, "Staff are respectful of my relative's space and autonomy. We have looked at specialist units, but they are in the middle of nowhere, and they would have to live with much older people and wouldn't be able to just walk outside." However, although people gave some positive feedback we found areas of practice in need of improvement.

We found people were not always supported with personalised care, and that care plans did not always inform staff of how to respond fully to meet people's emotional and social care and treatment needs.

Some people had a lot of control over what they did during the day; they accessed activities in the community and were actively involved with their care planning. One person told us, "I spend my day where I wish, mostly visiting my relative. I enjoy watching a film and having a walk." However, some people had less control over their lives due to their mobility or progressive health needs and were more reliant on good personalised care and support plans being available to detail their preferences and guide staff. Care plans had been reviewed and gave general information about people's likes and dislikes, personal life histories, health needs; including information on how progressive health conditions presented, and risk assessments. One person's care plan detailed that they liked to have a particular brand of water during the day, and we observed that this was provided. However, people's care planning did not always capture people's changing needs and lacked guidance for staff on how their emotional needs could be met. For example, one person told us they had lost confidence in travelling independently due to an incident in the community and were anxious about going out. They told us the registered provider had taken them recently to see some live music, but mostly they stayed in and how they missed their independence. There was a lack of guidance in their care plan detailing the importance for the individual of going out and having access to meaningful activities to ensure they did not become socially isolated. A relative told us, "Staff are competent, physical needs are met, but I don't think there is any stimulation".

People's personal interests, like and dislikes and chosen activities were discussed in care plans. People told us that there were no activities at the home, however where people could independently access the community they were able to take part in preferred activities. One person told us, "I go out and I visit a fish and chip shop every fortnight, Thursday and Saturday". One staff member told us that people living at the home no longer wanted to do a lot of activities. We do try but they just want to do their own thing. They find us when and if they want something". Another person told us, "I spend my day indoor watching television, I choose to do so".

We observed throughout the day that staff contact with people was variable, with most contact taking place

at meal times and less in the morning and afternoon. Records of residents meetings and surveys demonstrated that choice, activities and concerns were discussed and actions had been agreed in response. For example, meal choices were increased, shower facilities improved and the activity programme reviewed. However, the provider acknowledged resident meetings and activities including a singer visiting the home had not been sustained as people did not always want to take part.

Staff told us that they didn't always have time to spend with people to support activities when people who could not access their local community independently. One staff member told us that, "I feel more like a domestic help then a carer," and gave an example of a person who was recently bereaved and becoming more socially isolated. "If I had more time, I could sit and read the paper with them, or sit in the garden or visit the sea front." We spoke with the person and they told us, that they had initially spent time in the communal spaces of the home but had little in common with the other people in the home. They spoke tearfully about their bereavement and confirmed they spent all their time in their room watching TV or listening to music, and were dependent on relatives and a volunteer visiting for company. There was a lack of guidance in their care plan detailing the significance of their loss or how the home could support them emotionally. For example, planned individual time and or signposting to bereavement support groups. This and the lack of planned social activities demonstrated that people's holistic needs were not consistently planned for or met.

The failure to assess people's care and treatment needs so that they included all their needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet peoples' information and communication needs. People's care plans included some information on communication needs relating to their health condition, vision and hearing. Some information was available to people in accessible format that used technology. For example, pictorial menus and audio books. However, this had not been developed as fully as it could be. For example, one person with communication difficulties had access to a computer but this media was not explored as a means of communication with the person and there was no use of door signage or large print documents. There was also a lack of flagged records that supported a heighted awareness of specific critical needs, for example where people lived with diabetes. The registered provider had an awareness of AIS through discussions with the local authority; however they had not developed a policy or established training on how to fully implement the standard.

We recommend that the provider obtains information, sources training and implements policies and procedures in relation to compliance with AIS.

Staff demonstrated that they promoted some positive outcomes for people living in the home. One staff member told us, " It's been really nice to see how we have made a difference" They gave two positive examples of how the home's stability had benefited people; including a previously homeless person supported to move to sheltered housing, and a person sectioned under the mental health act remaining in good mental health. When asked what they did to have created this stability they told us, "Just being here, good food and talking to people about any concerns". One person told us, they were happy, because they were drinking less alcohol, and another told us that their goal was to, "Be warm and eat well".

People and their relatives were aware that they could make a complaint and told us that they believed their concerns would be taken seriously by the registered provider. One person told us, "I would go straight to the manager". Another told us the registered provider was good at solving problems. There were systems in

place to record concerns and complaints and actions taken. A relative told us that the registered manager had been responsive to feedback and provided their relative with a towel rail and pictures when requested.

When needed, the home provided dignified end of life care for people. Staff gave an example where a person living at the home had been supported with end of life care involving community and specialist nurses so they could have their needs managed and remain comfortably at home. One staff member told us, "After all this is their home, in the end it was really peaceful. We did everything we could, it was what they wanted".

Requires Improvement

Is the service well-led?

Our findings

People and their relatives spoke positively of how the home was managed. One person told us, "It's well managed; the registered provider does their best." Another told us, "They take care of us, good food and accommodation". A relative told us, "Well led, I'm sure it is, they ring if they have any concerns about my relative, and I pop round and I'm always very welcome" The registered provider likes my relative and always makes time and talks to him." Another relative told us the home was "Well-oiled and well managed in terms of the day to day running of the home". Staff spoke positively about the registered provider. One staff member told us, "You could not wish for a better boss". However, although feedback was positive, we received some variable feedback about how the home was led and found areas of practice in need of improvement.

At the April 2016 inspection we found areas of management practice that needed to improve. Records were not always updated to evidence people's progress in their care plans, risk assessments were not always in place and feedback from people and their relatives had not been gained to inform improvements in the home. At this inspection we found improvements had been made in some areas. For example, the service had gained feedback from people and their relatives through residents meetings and annual surveys carried out in July 2017. People gave positive feedback in relation to care given, choices they could make and their living environment. When people requested improvements these were acted on and recorded and people told us they felt it had improved the home. For example, one person requested a thicker duvet and this was provided. However, we found further evidence at this inspection that people's risk assessments and care plans were not always updated or reflective of people's holistic and changing needs.

Quality assurance systems were in place to monitor the running and overall quality of the service, however there remains a concern regarding the providers overall ability to maintain standards and to continually improve the quality of care. This is the second consecutive time that the home has been rated as Requires Improvement.

The registered provider discussed in their Provider Information Return (PIR) they were committed to improving the home and external quality assurance audits were completed to promote this. We observed external audits, and internal audit schedules for accidents, medicines, fire safety and monthly health and safety audits. These demonstrated that the provider analysed trends and themes and designed action plans in response. However, these quality assurance and governance systems lacked the management scrutiny required to ensure that risk assessments and care plans were fully personalised, effectively reviewed or used to mitigate risks to people's wellbeing and safety. For example, placement assessments, risk assessments and care plans were not detailed enough to fully inform or guide staff on how to meet people's needs. Staff did not always have access to training that would support their understanding of people's changing needs. Mental Capacity Act 2005 (MCA) assessments were not always completed to ensure people's capacity was suitably assessed and accident reports audits did not sufficiently scrutinise the suitability of investigation outcomes and actions. The internal and external audits that were completed to ensure the service was of good quality failed on many occasions to identify poor performance. Accident reporting audits did not sufficiently investigate outcomes and actions.

There were shortfalls in the provider's processes for assessing and monitoring the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider failed to display their most recent CQC performance assessment. Providers must ensure that their ratings are displayed conspicuously and legibly at each location delivering a regulated home and on their website if they had one. The home was inspected in April 2016; however during the inspection the provider had not displayed the rating of the home. This was raised with the provider, who confirmed it had been over looked, and that they would display the rating without delay.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 and will be dealt with outside of the inspection process.

The registered provider and staff worked closely with known health professionals such as the local GP's and speech and language therapists. We contacted a health professional who gave positive comments about the caring approach of the staff. One health professional told us that staff had contacted them appropriately when they had noticed a change in someone's wellbeing. They confirmed that staff were really helpful, and the person was encouraged and supported to be aware of their own health needs. The registered provider told us they worked closely with health professionals. However, although the registered provider had contact with known health professionals, they acknowledged they had less awareness of the community adult social care and health professionals that could support people with more complex needs. For example, community probation service, bereavement groups and substance misuse services.

We recommend that the provider develops its links with local community adult social care and health professionals, obtains information and sources training in relation to people with more complex needs.

The registered provider was supported by an established deputy manager and one senior support worker. During the inspection the deputy manager was absence and had been for two months. The registered provider had the ongoing support of a consultant during this time and made themselves available on call if staff needed support. They acknowledged this was not sustainable and were in the process of recruiting two new staff. One staff member told us, "The registered provider is here seven days a week. We can ring them anytime of the day and night". People, relatives and staff told us that the registered manager was very present at the home. Staff and relatives told us that there were defined roles and areas of responsibility within the management arrangements. For example, the registered provider told us that medicines were administered by themselves, the deputy manager or the senior support worker. Staff told us that their roles were changing as the needs of people being supported became more complex. One staff member told us, "I love this place although we have more challenging residents now; it's been really nice to see how we have made a difference". Another told us, "It can feel overwhelming at times, it's changed so much its unrecognisable what we do. I feel I am just a domestic staff". We shared this varied feedback with the registered provider who acknowledged staff roles had changed.

The registered provider stated in the Provider Information Return (PIR) that they valued an open door policy, "By listening to staff and our clients, we are able to work better as a team and provide better care". One staff member told us, "The manager is very good, any issues can be discussed". Relatives told us that they would discuss any concerns they had with the managers and were confident they would be heard. The registered provider notified us of events that occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. There was a policy in place in relation to the Duty of Candour that detailed the provider's

responsibilities. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

During the inspection we observed the registered provider and staff promoting compassion, dignity and respect by how they spoke to and about the people and their staff. Staff were positive about supporting people. One staff member told us, "The clients they are all great and deserve to live in a safe place where we all care about them. We pride ourselves on our family environment." Another told us, "We are one big happy family, the registered provider and deputy manager just pitch in".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9 (3) (a)(b) The provider had not ensured that the design of the care and treatment plan supported the peoples preferences and ensured their holistic needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) (2)(a)(b)(c) The provider had not ensured people were provided with safe care and treatment by assessing and mitigating risk to service users health and safety or ensuring the safe and proper management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1)(2)(a)(b) The provider had not ensured that the quality and safety of the service was assessed , monitored and improved, or that risks relating to health and safety were assessed and monitored to mitigate risk