Elmwood Residential Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Elmwood residential home is registered to provide accommodation with personal care for up to 38 people. The home is mainly for people over 65 years of age who may have physical disabilities, long term medical conditions or memory loss. 37 people lived at the home when we visited.

This unannounced comprehensive inspection took place on 13 and 14 September 2017. This inspection was to follow up to see whether improvements had been made from the previous inspection in January 2017.

At the previous focused inspection on 25 January 2017 the service was rated as requires improvement overall, with responsive and well led rated requires improvement and safe rated as good. We did not inspect effective and caring domains at the inspection. Two breaches of regulations were found in relation to good governance and in response to complaints. Although some aspects of quality monitoring had improved since our previous inspection in August 2016, it was still not fully effective. This was because of some gaps in people's care plans and daily records and because some complaints had not been robustly dealt with. Following the January 2017 inspection the Care Quality Commission (CQC) took enforcement action and served a warning notice in relation to good governance. This required the provider to make the required improvements by the 10 July 2017. In response, the provider submitted an improvement action plan.

Following this inspection in September 2017, we have now rated the service as 'requires improvement' overall on four successive inspections. A breach of regulation 17, good governance, has been identified at the last three inspections. This demonstrates the providers' quality monitoring systems were still not effective and they have not fully complied with the warning notice.

Previously on 2 and 3 August 2016 a comprehensive inspection rated the service as requires improvement. This was because we found two breaches of regulations in relation to people's safe care and treatment and good governance. Prior to that, on 21 and 28 April 2015, a comprehensive inspection rated the service as requires improvement overall, with three breach of regulations relating to person centred care, consent and safe care and treatment.

On 12 April 2017 we met the provider and the registered manager and set CQC's expectations that at the next inspection, all required improvements should have been completed with no breaches of regulations. We also emphasised the need to ensure these improvements were sustained over time. The service was also working with the local authority quality monitoring team to make the required improvements.

At our meeting on 12 April 2017 we asked the service to consider whether having the registered manager who also undertook the nominated individual (providers representative) role was the most effective way to monitor quality at the home. In response, the provider notified us that a director in the company was taking on this role. Since June 2017, a director has been based at the home.

The service has a registered manager in place. A registered manager is a person who has registered with the

Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had worked with the local authority quality improvement team to make improvements. They quality improvement team last visited the service in March 2017. Their report showed the service were making progress with improved quality monitoring systems, with further improvements needed in communication, direction and leadership.

At this inspection, improvements in some aspects of the quality monitoring systems had been made. However, the provider had failed to identify two new breaches of regulations and we found several areas for improvement. One breach related to the safe care and treatment regulation. The provider had previously complied with this regulation at the January 2017 inspection. However, this inspection found a breach in this regulation again. This showed the provider had failed to sustain the improvement.

People were not fully protected because a concern about suspected abuse had not been reported to the local authority or the CQC. The provider and registered manager did not demonstrate they understood their responsibilities for safeguarding. They failed to follow their own policy and procedures in responding to a suspected abuse incident. Staff understanding and knowledge about their safeguarding responsibilities also varied.

People were at increased risk because some environmental risks were not adequately managed. We found hazards due to contractors working in the home and some garden areas were not adequately maintained. Hazardous chemicals were not stored in line with the provider's risk assessments, legislation and guidance.

People received healthcare that met their needs. Staff had undertaken training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the arrangements for the care of a person who lacked capacity, did not demonstrate staff had considered the least restrictive options for their care.

People's care records had improved and individual risk assessments were well completed with actions taken to reduce risk. People and relatives said staff consulted them about any decisions needed, although this was not clearly captured in people's care plans. However, other correspondence between the service and people's families demonstrated this. Further improvements were needed in relation to accuracy and secure storage to protect people's confidentiality.

Improvements had been made in responding to complaints. People knew how to raise concerns and complaints, and were provided with information about how to do so. Any concerns raised were robustly dealt with.

People received their medicines on time from staff that were trained and assessed to manage medicines safely. However, improvements were needed in relation to prescribed creams and ointments and documenting when people declined their medicines. A detailed recruitment process was in place to ensure people were cared for by suitable staff.

People were well cared for by staff that had regular training to gain the knowledge and skills to support their care and treatment needs. People appeared happy and content in their surroundings, they were relaxed and comfortable with staff who knew people well and treated them with dignity and respect. People who received end of life care at the service were kept comfortable and pain free.

The service had enough staff to support people's care flexibly around their wishes and preferences. Improvements had been made in the variety of group and individual activities for people living at the home with an increased focus on one to one social contact.

People had access to healthcare services, staff recognised when a person's health deteriorated and sought medical advice promptly. People praised the quality of food and choices available. People were supported to improve their health through good nutrition and hydration. A new system had been introduced to identify to staff people that needed additional support with eating and drinking or were on special diets, which was working well.

Four breaches of regulation were identified at this inspection and the warning notice issued in March 2017 has not been met. CQC have taken further enforcement action by imposing a condition on the providers registration. This requires the provider to provide CQC with a monthly report outlining actions and progress in making the required improvements. We will inspect this service again within the next 12 months.

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

Some aspects of the service were not safe.

People were not fully protected because a concern about suspected abuse had not been reported in accordance with local authority or the provider's own policy and procedures. Staff did not fully understand their safeguarding responsibilities.

People's safety was at increased risk because some environmental risks were not adequately managed.

People received their medicines in a safe way, although some improvements were needed with regard to prescribed creams.

People's risk assessments were well completed with actions taken to reduce risk.

A robust recruitment process was in place to ensure people were cared for by suitable staff.

Is the service effective?

Requires Improvement

Some aspects of the service were not fully effective.

Staff had undertaken training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the arrangements for the care of a person who lacked capacity, did not demonstrate staff had involved their representative in a best interest decision or considered the least restrictive options for their care.

People were well cared for by staff that had regular training to gain the knowledge and skills to support their care and treatment needs.

People were supported to access healthcare services. Staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

People were positive about the choices and quality of food. Staff supported people to improve their health through good nutrition and hydration.

Is the service caring?

Good

The service was caring.

People and relatives said staff were caring and compassionate and treated them with dignity and respect.

Staff knew people well and developed positive relationships with them.

People were able to express their views and were involved in decision making.

People who received end of life care at the service were kept comfortable and pain free.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care records had improved. Further improvements were needed in relation to accuracy and secure storage to protect people's confidentiality.

Complaints were more robustly responded to. The complaints policy and procedure had been updated and people were asked if they had any concerns.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The service had a variety of quality monitoring systems in place to monitor the quality of care. Improvements were made in response to audits but failed to identify other areas needing improvement and four breaches of regulations.

We have rated the service as 'requires improvement' overall on four successive inspections. This demonstrates the providers' quality monitoring systems were still not effective.

Roles and responsibilities of senior care staff were unclear. The provider did not set clear expectations for staff about their performance.

People, relatives' and staff views were sought and taken into account in how the service was run.

Elmwood Residential Home Limited

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

This inspection took place on 13 and 14 September 2017 and was unannounced. The inspection team on the first day comprised of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses services for older people. One inspector completed the second day.

The provider completed a Provider Information Return (PIR). 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 included in the PIR along with information we held about the home, such as the provider's improvement action plan and notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met with 24 people using the service, and spoke with six relatives. We looked in detail at four people's care records including their medicine records. We spent time meeting with people in their rooms and in communal areas of the home. We observed interactions between people and staff. This helped us make a judgment about the atmosphere and values of the home.

We spoke with the registered manager, deputy manager, a director and 11 staff, which included care, housekeeping, kitchen and maintenance staff as well as an agency worker. We looked at systems for assessing staffing levels, staff rotas, staff training and supervision. We reviewed five staff files, which included recruitment records for new staff and information held about agency staff. We also looked at the provider's

quality monitoring systems such as audits, servicing and maintenance records, and provider quality monitoring reports. We sought feedback from commissioners, health and social care professionals who regularly visited the home and a member of the local authority quality monitoring team. We received a response from three of them

Requires Improvement

Is the service safe?

Our findings

Some aspects of the service were not safe. This was because some environmental risks were not adequately managed and staff did not fully understand their safeguarding responsibilities.

People were at increased risk because although environmental risk assessments were completed, we identified several additional risks. During the inspection contractors were working in the home replacing several internal fire doors. We observed numerous hazards for people, which were not being safely managed. Workmen had left electric power tools, a sharp knife and adhesive unattended and an electrical cord trailing across the path outside. This meant there was a risk people or others might access these items and have a serious accident. We immediately drew these hazards to the attention of the registered manager, who arranged to have them removed.

Some areas of the garden accessible to people were not adequately maintained. In the vegetable patch area the paths were uneven and other hazards included a trailing hose, roll of wire and an unsecured dilapidated shed. These risks increased risks of people having slips, trips and falls. One person said, "I haven't been in the garden for a long time because I don't feel safe. I feel safe going on the promenade [paved area just outside the house] because it's flat." Indoors, chemicals such as bleach and air fresheners were stored on shelves in bathrooms and corridor areas. This was despite a risk assessment about safe storage of hazards substances and the provision of a designated secure storage cupboard for chemicals. There was a risk that people or others may accidentally, swallow, inhale or suffer burns from these chemicals. This meant people were at increased risk because hazardous chemicals were not stored in line with current legislation and guidance. We brought these risks to the attention of the registered manager and asked them to ensure all chemicals were safely locked away.

This is a breach of regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 on premises and equipment.

Since the inspection, the deputy manager has informed us a section of the garden area has been fenced off, with further work underway to make it safe. There was an ongoing programme of repairs, maintenance and refurbishment to improve the environment of the home. Regular checks of equipment, such as hoists, hoist slings, and wheelchairs were undertaken.

People were not fully protected because the provider had not followed their own and local authority policies and procedures in relation to concerns raised about suspected abuse.

We followed up a complaint about a member of staff relating to an incident which occurred on 24 June 2017, which was reported to the registered manager on 25 June 2017. This was about suspected abuse of a person. The abuse incident was not reported to the local authority safeguarding team or notified to CQC, prior to the service carrying out its own investigation. Normally, it is the local authority that are the lead agency for safeguarding. It is they who advise the service about who will lead on any investigation.

We discussed the allegation of suspected abuse with the registered manager, deputy manager and two directors in the company. They confirmed they had discussed the incident when it occurred. They explained their decision not to raise a safeguarding alert or notify CQC was based on the fact the person had not displayed any sign of physical or emotional abuse and because there was no evidence of harm. The failure to report suspected abuse was not in accordance with the regulations, local authority safeguarding adults' guidance or the service's own safeguarding policy and procedures.

This is a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 re safeguarding service users from abuse and improper treatment.

Following the inspection, we requested and received a retrospective statutory notification from the service. The provider sent CQC a notification outlining details of the incident and the action taken in response. The registered manager said the person's care manager had subsequently reported the suspected abuse to the local authority safeguarding team.

The notification showed the staff member involved in the alleged abuse incident was dealt with through the provider's internal disciplinary procedures, supervision and retraining. We asked what information about the incident and the action taken had been shared with the person and family. The deputy manager explained the person lacked capacity and had no family. They confirmed the person's care manager had visited the person on two occasions since and said they were satisfied with the actions taken to protect the person.

We asked for information about safeguarding training. All staff including the registered manager and deputy manager had completed in house safeguarding training, which was updated annually. Only three staff out of the six staff asked were knowledgeable about signs of abuse and reporting arrangements.

Following the inspection, the inspector provided details of local authority level two and three training in safeguarding to the registered manager. Since the inspection, the registered manager, deputy manager and a director have confirmed they completed level two Safeguarding Adults and Mental Capacity Act Training on 24 September 2017.

People said they felt safe living at the home. People's comments included; "It's very nice to know there is someone handy to give you a hand." A relative said, "I know she is safe there." We asked people if they would know what to do if they didn't feel safe. Their responses included; "I would speak to deputy manager, or manager" and "The staff here are very good. I can always go downstairs and find them ."

There was an up to date fire risk assessment, and staff received regular fire safety training and did fire drills. Each person had a personal emergency evacuation plan which showed the support they needed to safely evacuate the building in the event of a fire. Contingency plans were in place to support staff to deal with any emergencies which might affect people's care such as disruption to electricity, gas and water supplies.

People's risk assessments were well completed with guidance for staff on how to minimise those risks. For example, in relation to falls, malnutrition and skin breakdown. Staff were aware of people's individual risks, for example, for people at high risk of falling at night. Staff did hourly checks and used pressure mats to alert them when people got up, so they could offer to assist them. Research has shown regular checks have been proven effective to reduce people's risks of falls, by anticipating people's needs, such as by offering the person a drink or assistance to use the toilet.

Accidents were reported, with the exception of a person who fell when they were out with relatives, which

wasn't recorded in the accident book but was recorded in the person's records. Falls were also documented on a body map, which showed the location of any injuries or bruises sustained, so staff could monitor them.

There were enough staff to keep people safe and meet their needs. People said they received care at a time and pace convenient for them. The atmosphere in the home was busy in the morning with staff having more time to spend with people in the afternoon. Staff worked together in pairs, where people needed two staff to help them with moving and handling and personal care. The service used a dependency tool to assess people's care needs and monitored the adequacy of staffing levels. Rotas were prepared in advance, so staff knew which shifts they were working. Any gaps in staffing were filled by existing staff working extra shifts or by using agency staff.

The service had a cordless call bell system in place, which meant people could use their call ball to call staff for assistance anywhere around the home including in the garden. Asked about call bell response times people's comments included; "It's very good;" "I have my bell and if I need anybody I can ring. There's not usually a long response; it's pretty good;" and "Sometimes they are very busy, but they are as quick as possible. They will come and explain if they will be late."

People received their medicines safely and on time and staff were knowledgeable about people's medicines. We observed a staff member give a person their medicines; they explained what the medication was for as they gave it to the person. One person said, "I get it in a pot and they make sure I take it before they leave the room."

Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Medicines were securely stored and there were systems in place for accounting for all medicines entering and leaving the home. Temperatures of the medicines room and the medicines fridge were checked daily to ensure medicines were stored within manufactures recommended temperatures.

Medicines administered were well documented in people's Medicine Administration Records (MAR), as were any allergies or sensitivities. However, records of administration of people's prescribed creams and ointments kept in their bedrooms did not include the prescribing information. When we cross checked with two people's prescriptions, we found their creams were not applied at the frequency prescribed. We raised this with the registered manager who said they would add this information to cream charts kept in people's rooms.

Medicines were audited monthly and any areas for improvement identified were implemented. For example, when staff were regularly forgetting to give a person their calcium supplement, the deputy manager arranged for the pharmacist to add it to the person's 'blister' pack where all their other medicines were kept. However, where people declined to take their prescribed medicines, there were some recording inconsistencies, sometimes staff recorded this, other times they didn't.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed including agency staff. Staff had police disclosure and barring checks (DBS), checks of qualifications and identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

People were cared for in a clean, hygienic environment and there were no unpleasant odours. Staff had access to hand washing facilities and used gloves and aprons appropriately. Housekeeping staff had suitable cleaning materials and equipment. An environmental health inspection carried out during the inspection awarded the kitchen a top rating of five out of five.

Requires Improvement

Is the service effective?

Our findings

Some aspects of the service were not fully effective. Staff had undertaken training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the arrangements for the care of a person who lacked capacity, did not demonstrate staff had considered the least restrictive options for their care.

The Mental Capacity Act (MCA) (2005) 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the Deprivation of Liberty Safeguards (DoLS), and found they were, although some areas for further improvement were identified

Where people appeared to lack capacity, mental capacity assessments were carried out. Staff involved the person, professionals and family members in 'best interest' decision making, with one exception. The provider information return (PIR) showed the registered manager had made DoLS applications to the local authority DoLS assessment team for two people living at the home, and were awaiting their assessment. This was because they identified those people may be deprived of their liberty due to restrictions on their freedom, for their safety and wellbeing.

A person, who lacked capacity, had previously gone outside the service unaccompanied after their visitor left, when it was unsafe for them to do so. To manage this risk the service had created a poster with the person's picture to make visitors aware not to let the person out unaccompanied for their safety. A 'best interest' decision was documented about this. However, when we spoke with the relative who was their legal representative, they were unaware of this.

The registered manager said the person occasionally tried to go outside but could be easily distracted from doing so. Their care plan said, "Please can all staff be aware of my whereabouts and discourage me from going outside of the building alone." On the first day of the inspection the person tried to go outside, and the registered manager dissuaded them from doing so and encouraged them to move to another area of the home. The person's activity records showed they had previously enjoyed going out on bus trips but no longer did so, as it was not safe for them to do so. In October 2016 the person expressed a wish to go to the post office one evening, but staff had dissuaded them from doing so.

We asked the registered manager, deputy manager and another member of care staff whether they had ever tried to take this person outside in the garden or for a walk in their local area when the person indicated they wished to go outside. They had not tried this option and it had not been considered in the person's care plan. This did not demonstrate staff had considered the least restrictive option for them.

People were offered choices and staff sought people's agreement before carrying out any care and treatment. For example, about the time they wished to get up or go to bed, what they wanted to wear and how to spend their day. People were asked to sign their consent, for example, regarding the use of bed-rails. One person, who was a diabetic, told us that they had "a sweet tooth." They said that staff frequently reminded them of the need to reduce their sugar intake, but that they chose not to follow that advice. This was documented and showed staff respected the person's right to make unwise decisions.

Each person had an assessment of their individual needs and care plans gave staff guidance about how to meet those needs. For example, about how to manage one person's diabetes and another person's nutrition and hydration needs. Staff knew people well, they recognised and responded to people's changing needs. Staff noted any changes to a person's skin, and this was documented, with evidence of actions taken in response. For example, such as seeking advice of the community nurse, use of pressure relieving equipment, regular repositioning and skin care. Health professionals praised the standard of people's care, and confirmed staff contacted them appropriately and followed their advice.

People had access to healthcare services through regular GP and community nurse visits. To help maintain their health hey had regular dental appointments, eye tests and visits from a chiropodist. Advice had been sought from an occupational therapist about a suitable chair, to prevent one person from slipping from their chair . People's comments included; "They look after you very well. I go out for a pair of glasses and the dentist comes in." Visitors said they could contact the home anytime and speak to a staff member who knew their relative and could respond to their queries. They said staff involved and kept them informed about any changes in their relative's health, although two visitors said they wanted more involvement.

Staff received regular training to provide them with the knowledge and skills to meet people's needs. Commenting on having help with moving and handling, one person said, "There are always two people to help with the transfers, and I'm not rushed. They always make sure my feet are placed right." Another person said, "I have had falls. Staff come and assist you to get up and sit you in a chair and generally keep an ear open."

Staff reported positively about training at Elmwood. When staff first came to work at the home, they undertook a period of induction, and worked alongside more experienced staff to get to know people. A new staff member said they felt well supported. They were undertaking the Care Certificate, a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life. For a new member of maintenance staff, whose first language was not English, the registered manager had arranged translated instructions for them to help them undertake checks of the water system.

Staff undertook regular update training such as fire safety, moving and handling, safeguarding adults, understanding the Mental Capacity Act 2005 (MCA) and infection control. They also completed training relevant to people's individual needs, for example, staff had recently undertaking training on managing diabetes, nutrition, stroke awareness and on end of life care. The provider information return showed 15 of 23 staff had level 2 or above, Diploma in Health and Social Care.

Staff received support through regular supervision which provided an opportunity for staff to discuss their practice and receive feedback. For example, moving and handling, hygiene and infection control.

Most people gave us very positive feedback about the quality of food. People's comments included; "The food is excellent, I have no complaints. We are well watered and fed. If you do not like the choice they would suggest something else you could have;" and "Lovely, delicious. Good choice. Fresh vegetables, not frozen, fresh fruit and juice. If you want anything at all that's not on the menu they will get it." Several

people praised the main meal of roast pork, which looked attractive and was served with a selection of fresh vegetables. One person said, "It's nice and hot". Another person said they thought the menu was "a bit repetitive."

People were asked to select their food choices for the week ahead from the menu, but could change their choice on the day. There was a wide variety of choices including for people on special diets. Kitchen staff held up to date information about people's food preferences, their nutritional support needs and any special dietary requirements. Where people need pureed or soft food, it was presented it in an attractive and appetising way.

Since we last visited, the service had introduced a good practice system of red/green serviettes to improve people's nutrition and hydration. Red serviettes highlighted people who needed assistance to eat and drink, whilst green serviettes denoted people with special dietary needs. Following each meal a record of what each person ate and drank was kept. Where any concerns about people's food and fluid intake were highlighted, these were acted on. For example, a person had only eaten one type of food for some time. Over the past couple of days they had stopped eating and were now included in the list of people who needed additional staff support with food.

Good

Is the service caring?

Our findings

Most people and relatives said staff were kind and caring towards them. People's comments included; "Everybody is friendly. You make your friends;", "Lovely, they chat to me;", "The best thing about the service is the girls, they are all very nice." Other people's comments included; "It's very good, on the whole they're (the staff) very caring, it's not the best but it's the best we're going to find……..the staff are willing to go with what you want……I've never been met with unkindness I can honestly say that; "One person commented; "It depends on the character of the carer." They went on to explain a member of staff showed a poor attitude when the person asked them to open their bedroom window, which made the person feel they were imposing, and were reluctant to ask again. Relatives comments included; "Care is so wonderful;" and "I'm so happy with the home, mum enjoys sitting out in the garden. All her worry lines have gone. I can enjoy visiting her. It feels like a huge burden has been lifted to know she is happy and well cared for."

Staff supported people to keep in touch with family and friends. One person said, "I visit my daughters who live close by." Family members and visitors were welcome to visit at any time, and offered a drink. Staff were preparing a party to help a person to celebrate their 100th birthday. The cook was preparing a special cake for them and other people were looking forward to the party. Another person who recently moved to the home had a 'Welcome to your new home' card on the windowsill from the service, and they were welcomed in the newsletter. The person had said in feedback, "Thank you for giving me a warm welcome and making me feel at home."

Staff developed positive, caring and compassionate relationships with people. The atmosphere was calm, relaxed. Staff were polite and helpful and spoke kindly to people and knew them well, their likes, dislikes and about their families. On the first day we visited a member of staff started their shift early in order to take someone to hospital for a planned operation. At lunchtime a person was eating very slowly. A member of staff noticed and sat beside the person to assist them and they started to eat more.

Several people and relatives particularly singled out the deputy manager to praise their caring and compassionate approach towards them. For example, the deputy manager went out into the garden to pick flowers for a person who was in bed. The person later said "She's so lovely she picks me flowers, she knows I love flowers."

People and relatives said staff consulted them about how they wished to be cared for and about any decisions needed, although this was not clearly captured in people's care plans. However, we found other correspondence between the service and people's families about their care in their care records.

People said staff treated them with dignity and respect and protected their privacy, with one exception. Staff asked people about whether they were happy to receive personal care from male and female staff and recorded their preference. They were discreet when supporting people with personal care, for example, covering a person with a towel when helping them to wash.

A poster was displayed in several areas which reminded visitors and staff not to let a person out

unaccompanied for their safety. Whilst well intentioned, we were concerned this solution was not very dignified for the person and breached their right to confidentiality. Since the inspection, the registered manager has advised us they have made the decision to remove this poster.

People said staff treated them with dignity and respect and protected their privacy. Staff asked people about whether they were happy to receive personal care from male and female staff and recorded their preference. They were discreet when supporting people with personal care, for example, covering a person with a towel when helping them to wash.

Care records were personalised about people's life and family history before they came to live at the home. They also included details of people's individual communication needs. For example, how one person was somewhat deaf and used hearing aids. A member of staff told us how they had established a particularly strong rapport with one person by singing to them. They told us how the person had become more talkative and started joining in the singing with them.

People were dressed in their preferred style, and assisted to wear their favourite jewellery and style their hair, where needed. Several people enjoyed having their hair done by a hairdresser who visited each week. People also enjoyed regular manicures from staff. People's rooms were personalised with things that were important to them. One person had their paintings hung on their wall, others had photos, cushions and stuffed animals. One person enjoyed the views of the sea and hills (where she used to regularly walk).

People enjoyed lunch in the dining room in an unhurried atmosphere. The tables were attractively presented with cloth tablecloths and napkins, with condiments, jugs and glasses on each table for people to help themselves. A staff member checked if a person needed any help cutting up their food. When a person hadn't eaten all their food, staff checked if they had finished their meal before clearing away their plate.

People were supported with their religious needs. One person said, "You can go to church. They do have a service here, but they will take you to church if you wished to." Six people visited their local church once a month.

People had Treatment Escalation Plans (TEP) in place. These are legal forms completed by the person's GP. They outline what medical interventions the person wants to receive in the event of their becoming unwell. People were supported to discuss and make any advanced wishes about their end of life care known.

People who received end of life care at the service were kept comfortable and pain free. The service had worked with the hospice to increase staff skills in providing end of life care. When a person died they were fondly remembered in newsletters and spoken about at residents meetings. Relatives particularly appreciated the standard of end of life care staff gave people. Feedback from relatives who had died at the home included; "Sincere gratitude for the three plus years of care given to our dad. We saw an amazing transformation of his wellbeing and level of contentment and enjoyment of life;" and "He was able to stay cared for by those who knew and appreciated his needs. We are so grateful he was able to remain peacefully and so carefully and lovingly tended, which has been an enormous comfort to us. The level of personal care and loving support has been humbling to witness."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we identified breaches of regulations related to gaps and inconsistencies in people's care records and in a lack of robustness in responding to complaints. Improvements had been made in both these areas although further improvements in record keeping were needed.

People's feedback about the home included; "They are so good to me because I need a lot of help;" "They are all very good. I haven't found any problems. I expect they would [help me] if it was necessary;" "Yes, if you have a worry, you can talk to anybody;" and "It's pleasant enough, quite okay. I talk to most people. If people talk to me I talk back."

People's care records had improved, they were more personalised and detailed about individual care needs. For example, people with diabetes had individualised care plans about their dietary, skin care and medicine needs. For a person dependent on staff for their nutrition and hydration, their food and fluid charts were fully completed and up to date.

In July 2017, a new computerised care records system was introduced to the home. Staff had undertaken two days training on the system and used hand held electronic devices to complete daily records of people's care, and of eating and drinking. The electronic records were being used alongside existing paper records, with some duplication. There was no timetable for full implementation. At a staff meeting on 11 September 2017, teething problems related to the recently introduced electronic records and ways to overcome them were discussed.

In some people's care records, a few documents were not dated, some appeared to contain information that was out of date, compared with other documents within the same file. This suggested some needed to be archived, as they were no longer relevant. Entries in one person's care records about their involvement in care planning were confusing and contradictory. An entry said, "I am involved with my personalised care and plan with [the registered manager and deputy manager]. However, other parts of their care record showed the person lacked capacity as they had advanced dementia and was unable to speak.

People's care plans were kept in an open filing cabinet in the staff office, adjacent to the main corridor, that visitors regularly accessed. Other confidential information such as people's daily records were stored on a table in the office. Information for staff about people's nutrition/hydration needs displayed on the wall. Staff were in and out of the office all day, but it was unmanned at times. We fed this back to the registered manager, who has contacted us since to advise this office is now locked at all times.

Care plans were written in the first person to show they represented the person's views. However, since we last visited, the service had also started completing people's daily records, in the first person. This was somewhat confusing as they read as if people were completing their own daily records, whereas staff had clearly completed them. We asked the registered manager about the reason for this change. They said they had made this change to make records more personalised and because they thought CQC would prefer this. Feedback from staff was they found this change difficult and confusing. We assured the registered manager

the regulations about record keeping did not require this, so they decided to revert to the previous arrangements.

New staff said they were given time to read and familiarise themselves with people's care records. Existing staff said they thought people's care records accurately reflected people's current care needs. However, most staff said they relied more on staff handover and information from the deputy manager to keep them up to date with changes.

People said they were very happy living at the home, and most didn't have any complaints. One person had raised a concern about having to wait for a member of care staff. They confirmed they were satisfied with how it was dealt with. When asked who they would raise concerns or complaints with, most said they would talk to the deputy manager or registered manager. One person said, "I would probably talk to (deputy manager) because she would be the one who could deal with it ……and if necessary she would consult with (manager)."

Improvements had been made in how the service responded to complaints. The complaints policy and procedure had been updated and included contact details of other organisations people and relatives could contact if they were dissatisfied with how their complaint was handled. Complaints information had been given to each person. A new complaints log showed all verbal and written complaints received and demonstrated the actions taken in response. For example, related to repairs needed and about noise at night. The service had received 10 complaints and 35 compliments in the past 12 months. Where conduct or issues relating to attitude were raised about individual staff, there was evidence of more robust actions taken in response. At residents meetings, people were asked if they had any concerns and actions taken in response were documented.

People received personalised care that responded to their needs. Staff knew people well, recognised any changes in their health or care needs and took appropriate action in response. Speaking about personal care, one person said, "I don't like the shower, I prefer a bath." Another person said, "They are lovely. I had a bath today. I am not scared to say no." Their relative said, "They smother her with cream" and said their mother's skin was very smooth as a result.

Staff checked whether a person was ready for their wash, and whether another person needed their food cut up to help them eat independently. When a person we spoke with looked uncomfortable in their chair, staff responded immediately when the person asked them to help them.

People enjoyed a variety of activities and leisure pursuits. One person said, "If I get a bit fed up being on my own, I come down to the lounge. There's always someone who can tell you [what is on]. Another person said, "We have something going on weekdays." One person said, "I can't say I get lonely. I am an only child so I am used to being by myself, so it doesn't bother me." Another person said they felt a little bit isolated in their room sometimes but could go to the sitting room for company. A volunteer befriender from the local hospice visited two people confined to their room once a week, to keep them company and prevent isolation. Staff visited and spent time with both people regularly throughout the day. A person who was confined to their room had their radio on and was holding a favourite stuffed soft animal. The service had access to a minibus they used to take people on trips and escorted people to local health appointments.

Staff supported a person to feed a hedgehog in the garden. They had provided a plastic box to put food outside to attract the hedgehog. Another person liked watching the birds visiting the bird box outside their bedroom window. Others said they liked going in the garden, watching TV, and listening to the radio. Several people enjoyed spending time watching the fish in an aquarium in the lounge. Others enjoyed spending

time in the garden, and a relative of one person said, they would like staff to encourage and help the person to get out in the garden more often, although said the person might refuse.

Two staff had become more involved in providing a planned programme of activities for people. A weekly calendar of activities planned for each week was on display in communal areas and a copy given to each person. This included quizzes and board games, bus trips and musical entertainment. A person living at the home with their sister ran a 'Knit and Natter' activity, which was very popular. Regular film nights were held and minutes of a residents meeting in September 2017 showed this was so popular, a second film night was being introduced. People wanted to watch a film and eat their supper at the same time. A new gardener had been appointed who spoke about plans to involve people in gardening in the spring. People's activity records were well documented and showed what individual and group activities they enjoyed.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 25 January 2017, some aspects of quality monitoring were still not fully effective. This was because breaches of regulations were found related to complaints and good governance which had not been identified through the provider's quality monitoring systems. The Care Quality Commission (CQC) took enforcement action, and served a warning notice on the provider on 9 March 2017 in relation to good governance, which required them to comply with this regulation by 10 July 2017.

At this inspection, although improvements had been made in some aspects of the quality monitoring systems, they had failed to identify further breaches of regulations found. The service failed to notify CQC about an allegation of abuse. Deficiencies in the provider's safeguarding policy and procedures were identified, and they failed to recognise suspected abuse or follow their own policy and procedure for managing it. People's safety was at increased risk, because of a failure to properly manage and minimise environmental risks. Inspectors identified others improvements needed in medicines management, restrictive practices and a breach of confidentiality for one person, and about accuracy and security of records. Whilst the provider took action to address these, none of these were identified through the provider's own quality monitoring systems.

When we met with the provider on 12 April 2017 we set CQC's expectations that at the next inspection, all required improvements should have been completed with no breaches of regulations. We also emphasised the need to ensure these improvements were sustained over time.

At this inspection, the safe care and treatment regulation was breached again, having been complied with at the January 2017 inspection. This showed the provider has failed to sustain this improvement. We have rated the service as 'requires improvement' for the fourth successive inspection. The domain of 'well-led' was rated as 'requires improvement' on the previous two inspections and is rated 'inadequate' at this inspection. A breach of regulation 17, good governance, has been identified for the third successive inspection. This demonstrates the providers' quality monitoring systems were still not effective and they have not complied with the warning notice.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations.

We checked our records and found CQC had not received any safeguarding notifications from the service about suspected abuse since the provider's registration on 1 October 2010. This could mean abuse or suspected abuse is not being recognised or reported. A safeguarding notification had not been submitted to CQC when there had been an allegation of abuse in June 2017.

This is a breach of regulation18 of the Health and Social Care Act 2008 (regulated Activities) Regulations.

Quality monitoring systems included audits of care records, activities, health and safety of the environment, and medicines management, use of checklists and regular meetings with people and staff. A service improvement plan showed actions being taken in response. For example, a care record audit identified a

person needing a care plan for a new health need, and that the complaint procedure needed updating, which were completed. Broken window restrictors and carpets had been replaced. A food themed satisfaction survey (undated) showed people reported high levels of satisfaction with the quality of food. Amendments were made in response to people's individual feedback to incorporate their preferences and a new 11 week rolling menu was agreed.

In June 2017 the registered manager of another home within the provider group undertook an audit at the home. This included looking at people's care records and the environment. The report identified further improvements needed in care records and people's personal files, where both areas scored 50%, and health and safety was 88%. The registered manager said they had found this useful and areas they needed to address were added to the service improvement plan. The registered manager said they planned a reciprocal visit to carry out an audit of the other home, within the group, but hadn't yet arranged a date. We asked the registered manager whether the service had worked with the other home within the group who had already successfully implemented the electronic care records. They said they had undertaken the training there and planned another visit there soon to see how they dealt with some of the current difficulties encountered.

We met with the director based at the home and asked them how they were monitoring quality. They said they met with the registered manager weekly to review the improvement plan and any audit findings. They were available on a day to day basis to discuss and support the registered manager. For example, in relation to staff management issues and to arrange repair or replacement of equipment and furnishings. The director showed us a notebook containing notes of conversations with individual people they sought feedback from and any actions taken in response. For example, teaching a person how to use their answerphone and replacing a chair, and a blind. They also attended and participated in staff meetings. When we asked about further improvements planned, they identified plans to improve the website.

The service had a registered manager. They and their deputy manager worked weekdays and weekends between them. Staff said the registered manager and their deputy were approachable and supportive. An agency worker said the deputy manager had told her what needed to be done. She said, "The carers, they are lovely, we work together." One member of staff spoke of tensions between some staff and said, "I would like to have more responsibilities." Another said "There is nothing bad, or good, it is just ok."

Improvements in communication within the staff group had been made through the introduction of regular staff meetings. These provided staff with an opportunity to talk with management and be involved in day to day decisions about the running of the home. Staff said the introduction of team meetings had been positive and useful. Minutes from 11 September 2017 staff meeting showed suggested improvements discussed at the previous meeting had been implemented. For example, in relation to additional equipment requested, and improvements in marking laundry. Other issues discussed included activities, and staff suggested ways to make it easier for people and agency staff to find their way around the home.

Staff referred day to day queries and decision making directly to the deputy manager or the registered manager. Developing the senior care staff role to take on additional responsibilities for day to day decision making was something we had raised when we last visited. At that time the deputy manager described difficulties getting senior care staff to take on that role. We asked the registered manager how senior care staff were recruited and selected. They said staff usually became senior care staff when they had worked at the home for several years. However, there was no job description setting out their role and responsibilities. We remained concerned that management were not delegating responsibilities sufficiently to develop senior care staff and were not setting clear expectations of all staff about their performance. Since the inspection, the registered manager has advised us they have developed a job description for that role.

The service had a safeguarding policy which had been reviewed in October 2016 and outlined signs of abuse and actions to be taken in the event of suspected abuse. However this policy was not up to date about regulatory changes from The Commission for Social Care Inspection to the CQC. The policy did not include the contact details for the local authority safeguarding team, police or CQC. This would make it difficult for staff to contact the relevant agencies about suspected abuse. We fed this back to the registered manager who subsequently sent us an updated safeguarding policy, which included those contact details.

Accidents and incidents were monitored and audits of falls were undertaken. For example, for a person at high risk of falling out of bed, whose risk assessment showed they were not suitable for bed rails, the service had obtained a 'Hi Lo' bed. This meant the person could be positioned near the floor at night to minimise their risk of injury if they rolled out of bed.

People were consulted and involved in decisions made about the home. The registered manager and their deputy shared an office in the centre of the home. People and visitors frequently popped in and out of the office to chat and raise any questions or worries. Regular residents meetings were held, chaired by two care staff.
Minutes showed people were involved in deciding about menus and what they wanted to spend their time doing. Minutes of the most recent meeting on 4 September 2017 showed people discussed food choices for supper and suggested popcorn for film nights. A person had previously asked to have a lock fitted on their door and this had been fitted. Speaking about residents meetings, one person said, "If it's something they can't answer right away they will go to the trouble of finding out for you. It gets followed up if it's necessary and we get to know the outcome."

Following the success of the red/green serviette system in raising awareness of people's nutrition/hydration needs, the deputy manager outlined a further improvement they planned to introduce to highlight people with new health care needs. They planned to use a blue triangle to highlight to staff a change in people's care needs, for example, in pressure area or wound care needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service failed to notify the Commission about an allegation of abuse. Regulation 18 (1) (e)

The enforcement action we took:

Imposed a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with safety of the premises. This was because risks related to contractors working in the home were not safely managed. Also some garden areas were not adequately maintained and because hazardous chemicals were not stored in line with legislation and guidance. Regulation 12 (1) (2) (d)

The enforcement action we took:

Imposed a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not fully protected because the provider had not followed service and local authority policies and procedures in relation to concerns raised about suspected abuse. Regulation 13 (1) (2) (3)

The enforcement action we took:

Imposed a consition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not fully protected because quality monitoring systems were not fully effective. This was because they had failed to identify further breaches of regulations. Regulation 17 (1)(2) (a)(b)

The enforcement action we took:

Impose a condition