The Island Residential Home Limited

The Island Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
The Island Residential Home accommodates up to 34 people. At the time of our inspection, 28 people lived at the service. Some were older people living with dementia, some had mobility difficulties, sensory impairments and some were younger adults. Some people received their care in bed. Accommodation is arranged over two floors. There was a passenger lift for access between floors.

Rating at last inspection:
The last inspection was carried out on 06 February 2018. The service was rated Requires Improvement.

Why we inspected:
This inspection was brought forward in response to incidents that had occurred in the service and concerns that had been raised about the safety and management of the service. At the time of the inspection we were aware of incidents being investigated by third parties.

People's experience of using this service:
The provider did not have effective safeguarding systems in place to protect people from the risk of abuse. Some incidents of abuse had not been appropriately reported to the local authority or relevant persons. Risk assessments did not have all the information staff needed to keep people safe, because risk assessments had not been reviewed and amended as people's needs changed. This meant staff did not have up to date information to keep people safe.

Staff had not always been recruited safely to ensure they were suitable to work with people. The provider had not carried out sufficient checks to explore staff members' employment history to ensure they were suitable to work around people who needed safeguarding from harm. There were enough staff to support people's needs. The provider did not have a system in place to assess if staffing levels met people's needs. The provider had recognised this and had asked the manager to develop this tool.

Medicines were not always managed safely. Medicines were stored at safe temperatures in monitored clinical rooms and medicines fridges. However, one medicine fridge contained a urine sample which was stored alongside people's medicines. This was unhygienic and there was a risk that medicines could become contaminated. Medicines had gone missing in the service. Some people's care plans contained body maps for staff to record where medicine patches were applied. These were not always completed. This meant that staff could not be assured that the site of application was rotated to prevent irritation to people's skin.

The service was clean and we saw staff used protective equipment such as gloves and aprons. The flooring in one area of the service was damaged which prevented this from being effectively cleaned. We reported this to the provider.

People were not protected from harm because the provider had not been analysing accidents and incidents to look at causes or trends. This meant lessons could not be learnt from these events to reduce the same thing happening to others.

People were supported to receive meals which met their dietary requirements. People told us they liked the home cooked food. Staff had good relationships with healthcare professionals to ensure that people saw them when required. When people had been unwell or their needs had changed referrals had been made to relevant health professionals. However, records evidenced that some referrals had not taken place in a timely manner. Records of healthcare professional visits were not always documented, and instructions left were not always actioned.

Capacity assessments were inconsistent and did not always follow the Mental Capacity Act 2005. Some assessments made were not decision specific. People with capacity to consent to decisions about their care had not always signed consent forms. We made a recommendation about this.

The layout of the building met people's needs. The service had dementia friendly signage to help people find their bedrooms, bathroom or toilet and the lounge.

Assessments of people's needs had taken place after people had moved to the service. This meant that there had been some incidences of inappropriate or failed admissions. The new management team confirmed that plans were in place to carry out a detailed assessment prior to admission.

Staff told us they had received supervision meetings with their line manager to support their development. Staff received training which was effective and gave them enough information to carry out their duties safely to enable them to meet people's needs.

People were supported and treated with dignity and respect; and involved as partners in their care. We observed people being treated with kindness and respect by staff. Staff took time to talk with people and played games, which people enjoyed. People told us they felt that staff took time to chat with them and listened to them. People told us that the staff respected their privacy and dignity. We observed staff knocking on doors before entering rooms and closing the doors when they carried out personal care.

Some care plans were in place. These were not always relevant and up to date to detail how staff should meet people's needs. For example, people's epilepsy care plans did not detail what type of seizures each person had, and how long the seizures usually lasted. Staff were knowledgeable about people and their care and support needs. People had access to activities to meet their needs. Some people had some plans in place for their choices at the end of their life. Staff ensured people were supported at the end of their lives.

People knew how to complain and felt their complaints were taken seriously. The complaints policy was also available to people in a pictorial format. The complaints procedure was displayed in the service.

Records were not accurate, complete or contemporaneous. Many files and records were missing and could not be located at the service. Records of people's care were poor. There had been no audits or checks of the service completed since our last inspection by the manager. The provider had found this out through instructing an external consultant to carry out a review and audit of the service. The provider had arranged for the operations manager to carry out a comprehensive audit of the service and develop an action plan. This was carried out before we inspected and a copy of the action plan was given to CQC. The provider advised that they would send a monthly report to CQC to update the actions outstanding by the last working day of each month.

The provider had not effectively monitored the service to ensure that managers in post were carrying out their roles effectively. This meant that the quality of the service had deteriorated. Many of the previous improvements had been undone. The provider told us that they had learnt lessons from this. They had implemented a new staffing structure and recruited a new manager who was due to start on the 04 February 2019. They had put support in place to ensure the new manager received effective support, supervision and assistance to improve the service.

The provider had not always notified CQC about important events. One person sustained a serious injury in 2018 which had not been reported. People were invited to regular 'resident's meetings' where they were asked their opinions about the service. People's feedback had not always been acted on. The provider was in the process of gaining feedback about the service. Questionnaires had been sent to people who used the service and their relatives.

More information is in the detailed findings below.

Enforcement:
We identified four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. We also identified one breach of the Care Quality Commission (Registration) Regulations 2009. Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: Following the inspection, we requested an action plan and evidence of improvements made in the service. This was requested to help us decide what regulatory action we should take to ensure the safety of the service improves.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was caring

Details are in our Caring findings below.

Good

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

The Island Residential Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by whistle blowing concerns. The information shared with CQC indicated potential concerns about the management of risk of unsafe medicines management, infection control, safeguarding being from abuse, food quality and quantity, staffing levels and the environment. This inspection examined those risks.

Inspection team:
The inspection was carried out by three inspectors and one expert by experience. One of the inspectors specialised in medicines. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
The Island Residential 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 service was not registered to provide nursing care. Any nursing care was provided by community nurses.

The service did not have a manager registered with the Care Quality Commission. The service was being managed by a temporary manager. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The first day of this inspection was unannounced.

What we did:
Because we moved this planned inspection forward due to the concerns we received we did not ask the provider to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service including previous inspection reports. We also looked at notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to plan our inspection.

We spent time speaking with eight people who were living at the service. We also spoke with one person's relatives to gain feedback about the care and support their family member received. A number of people were not able to verbally express their experiences of living in the home. We observed staff interactions with people and observed care and support in communal areas.

We contacted health and social care professionals to obtain feedback about their experience of the service. These professionals included local authority commissioners and local authority safeguarding coordinators.

We spoke with 12 staff including; the cook, care staff, senior care staff, head of care, the temporary manager, the operations manager and the provider.

We looked at seven people's personal records, care plans and 11 people's medicines charts, risk assessments, staff rotas, staff schedules, two staff recruitment records, meeting minutes, policies and procedures.

We asked the provider to send us additional information after the inspection. We asked for copies of the training matrix, quality assurance analysis reports and medicines records. These were received in a timely manner.

Inadequate

Is the service safe?

Our findings

At our last inspection on 06 February 2018, the provider had failed to operate effective recruitment procedures and had failed to take appropriate actions to mitigate risks to people's health and welfare. We also recommended that the provider and registered manager reviewed practice in line with good practice guidance and the Misuse of Drugs Act 1971 to ensure medicines were recorded adequately.

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

● Risk assessments did not have all the information staff needed to keep people safe. One person had choked on 04 December 2018. Their risk assessment had been reviewed and amended on 03 January 2019. The risk assessment did not refer to the choking incident and did not show that the person was at risk of choking. Staff did not have up to date information to keep the person safe.

● One person had fallen out of bed on 11 January 2019. Their risk assessments had not been updated to reflect that they were now cared for in bed and were at risk of falling. A crash mattress had been placed next to the bed as a precaution to prevent injury from further falls, however other options had not been explored, such as bed rails with cushioning. We spoke with the provider about this. They had not known the person had fallen but had ordered a new bed to better meet their needs as they were now being cared for in bed. This bed and bed rails arrived during the inspection.

● Some people were diagnosed with epilepsy. There were also no risk assessments in place to detail what extra precautions were in place to support people with bathing or showering to prevent drowning.

● Another person's care records showed they had history of falling, particularly when under the influence of alcohol. The falls risk assessment which had been completed on 06 January 2019 showed they were at high risk of falls. The risk assessment stated that staff should assess the person when they fell and seek medical attention as appropriate. It also stated falls must be recorded on an incident form and reported to the management. This person had fallen in the night 14 days after the risk assessment had been completed, they reported this to their local authority care manager. There were no incident forms recording the fall and no written records in the person's daily records. One staff member we spoke with confirmed they knew the person had fallen.

● One person's pressure area risk assessment chart had not correctly identified the person's diagnoses and factored this into the risk assessment to give a clear idea of the risks to the person.

● People told us that they had been involved in discussions on how to keep them safe. Most people felt they had all the equipment they needed to keep them safe.

The failure to manage risks to people's health and welfare was a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff had not always been recruited safely to ensure they were suitable to work with people.

● The provider had not carried out sufficient checks to explore staff members' employment history to ensure they were suitable to work around people who needed safeguarding from harm. Both staff files contained unexplained gaps in their employment history.
● One staff member had a gap from leaving school in 1990 through to 2008 which the provider had not explored. Another staff member had unexplained gaps. Their interview notes showed that gaps were not discussed and reasons for gaps had not been explored or documented.
● References had been received by the provider for all new employees. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks in staff files.

The failure to operate effective recruitment procedures was a continuing breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed there were enough staff to support people's needs. Staff reported that staffing levels had been increased in one area of the service recently. On the second day of the inspection this number had decreased because of staff sickness.
● The provider did not have a system in place to assess if staffing levels met people's needs. The provider had recognised this and had asked the manager to develop this tool. We discussed that this tool should include night time support as well as key times during the day, such as meal times.
● People told us, "Always staff about if I need some help, when I fell at the bottom of the bed I had to shout out for help and staff came straight away" and "Enough staff, new ones who replace those leaving are just as good."
● Staff answered call bells promptly during our inspection visit. People we spoke with told us, "Fairly quick, might have to wait if they have to help someone else" and "At night if I press the buzzer they come very quickly."

Using medicines safely
● Medicines were stored at safe temperatures in monitored clinical rooms and medicines fridges. However, one medicine fridge contained a urine sample which was stored alongside people's medicines. This was unhygienic and there was a risk that medicines could become contaminated.
● One of the clinical rooms was also used as a staff room and all staff had access. We were told that keys to locked medicines cupboards were restricted to authorised members of staff. However, before our inspection the service had reported that some medicines had gone missing, including controlled drugs (medicines that require extra security due to their potential for misuse). The provider was investigating the incident and new security measures were being introduced. Staff carried out balance checks of controlled drugs at each shift handover and recorded these in the controlled drug register. During our inspection we found that balances were correct.
● Two members of staff checked and signed for medicines when they were delivered to the home. Staff did not record the total quantities of medicines and therefore it would be difficult to account for all medicines and ensure stocks were always available when people needed them.
● On the day of the inspection staff were unable to show us any completed medicines audits. The provider explained that they were introducing new systems to monitor the safety of medicines and completion of records on a weekly and monthly basis.
● We looked at medicines administration records (MARs) and care plans for 11 people. Each person had a section in the MAR folder with their photo to enable staff to identify people. Some medicines were prescribed on a 'when required' basis. There was guidance in place for staff to understand what circumstances people may require them.
● Staff applied creams to people during personal care and recorded the application on the same MAR.

Some people's care plans contained body maps for staff to record where medicine patches were applied. These were not always completed. This meant that staff could not be assured that the site of application was rotated to prevent irritation to people's skin.

● One person was prescribed a varying dose of their blood thinning medicine and required a different number of tablets on some days. The person's MAR showed that staff had not followed the instructions properly and had recorded that the person had been administered more tablets than was prescribed on two occasions. This meant that the person was at risk of bleeding. We raised this with the manager, who contacted the GP for advice.

The failure to manage medicines safely was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Accidents and incidents were inconsistently documented. They could not be clearly analysed and lessons learnt were not documented.

● Actions that had been recorded on accident forms had not always taken place. One person had choked on food whilst eating their meal in December 2018. They had received appropriate first aid at the time of the incident. However, they had not been referred to their GP or Speech and Language Therapist (SaLT) as stated on the form. The temporary manager referred the person to SaLT during the inspection.

● Another person burnt themselves whilst independently showering in December 2018. Medical help was requested at the time of the incident but action to get the shower checked to make sure other people were not at risk had not happened. Six days after the incident the handyperson checked turned down the water pressure, however the built in thermostat in the shower had not been checked. We reported this to the provider who arranged for a plumber to visit the service during the inspection.

The failure to evaluate, monitor and improve practice demonstrates a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The service was clean and we saw staff used protective equipment such as gloves and aprons.

● The flooring in one area of the service was damaged which prevented this from being effectively cleaned. We reported this to the provider.

● The equipment and the environment had been maintained. Handypersons carried out repairs and maintenance in a timely manner.

● Some of the maintenance records were confusing, the handyperson had reported this to the provider and improvements were being made.

Systems and processes to safeguard people from the risk of abuse

● The provider did not have effective safeguarding systems in place to protect people from the risk of abuse. The provider had not always followed safeguarding policy; some incidents of abuse had not been appropriately reported to the local authority or relevant persons.

● Staff we spoke with had a good understanding of what to do to make sure people were protected from harm or abuse. Staff had confidence in the new management team to appropriately deal with concerns.

● People we spoke with told us that they felt safe. People we spoke with told us that if they didn't feel safe they would speak with a member of care staff or management team. People said, "I would see the senior, then the assistant manager and then to the manager if I wasn't taken seriously" and "I am the tenant representative here and if I saw or was told something which wasn't right I would raise it straight away with the manager."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Supporting people to eat and drink enough to maintain a balanced diet
● Some people required their food and fluids to be monitored and recorded. Records were inconsistently completed, some days no records were made and other days some entries had been recorded.

The failure to make accurate and complete records was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People were supported to receive meals which met their dietary requirements, this included the texture they needed to reduce the risk of choking. People who were vegetarian were offered a variety of options and food was purchased to meet their needs.
●People told us they liked the home cooked food. They said they were offered two choices for their lunchtime meal each morning and that if they did not like either choice they could request something else. Comments included, "Lovely food, Sunday roast is my favourite. I have toast in the morning, [Person], one of the other residents makes for me"; "Food has really improved, plenty of options. I am a diabetic and for pudding cook makes sure I don't have too much sugar and will do me fruit and ice cream, always offer do you want any more" and "I get offered a choice every day, food always tasty. I try and feed myself, staff prop me up and check I can reach the plate. If I am having a bad day I ask the staff to feed me."

Supporting people to live healthier lives, access healthcare services and support
● There were good relationships in place between staff and healthcare professionals to ensure that people saw them when required. Community nurses visited the service frequently to administer Insulin and provide nursing care.
● Some people had experienced long delays in receiving emergency medical attention. Records showed that people had sometimes waited five to seven hours for an ambulance because the ambulance service was busy.
● When people had been unwell or their needs had changed referrals had been made to relevant health professionals. However, records evidenced that some referrals had not taken place in a timely manner. This is an area for improvement.
● People's care plans showed that health care professionals had been involved in people's care when appropriate.
● People told us that the staff were good at getting medical care for them. People said, "The district nurse comes in and checks my feet and redresses them every couple of days" and "When I felt really poorly with a chesty cough, the doctor came in straight away and prescribed antibiotics and told me drink a lot more. The district nurse comes every three months to change my catheter."

● Advice from health care professionals was taken seriously and entered in people's care plans and actioned by staff. One person had been expressing suicidal thoughts. Staff contacted the person's mental health specialist and sought advice. Records showed that the advice had been followed and the person had been taken to hospital to gain essential treatment and to keep them safe.
● Records of healthcare professional visits were not always documented, and instructions left were not always actioned. For example, one person had received a course of physiotherapy, when this had been completed staff were asked to contact an occupational therapist regarding a sling assessment. There was no recorded follow up to this, one member of staff said they thought a call had been made but weren't sure.

The failure to make accurate and complete records was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● The manager had correctly applied for DoLS within the MCA for people living at the service. Some of these applications had been authorised by the local authority at the time of this inspection.
● MCA assessments were inconsistent and did not always follow the MCA 2005. Some assessments made were not decision specific. One person's assessment dated March 2018 stated the person lacked capacity to 'make significant decisions' about their life and care.
● People with capacity to consent to decisions about their care had not always signed consent forms. Some people had signed forms to consent to sharing of their information and photographs.

We recommend that registered person's review practice in best interest decision making, following the Mental Capacity Act 2005 code of practice.

● We observed that people made decisions about their care and treatment. We heard people declining and accepting offers of food, drink, personal care, people chose whether to participate in activities.
● People told us that staff encouraged them to make their own choices about the assistance they had and would always ask permission before helping them. Comments included, "Able to choose when I go to bed or when I get up" and "Before I have a bed wash staff ask is it alright to wash your back now before they roll me onto my side."

Staff working with other agencies to provide consistent, effective, timely care
● Staff told us they worked closely with health and social care professionals to enable them to meet people's needs.
● Records showed that this included specialist nurses such as Parkinson's disease nurses, opticians,

occupational therapists and physiotherapists.

Adapting service, design, decoration to meet people's needs
● The layout of the building met people's needs.
● The service had dementia friendly signage to help people find their bedrooms, bathroom or toilet and the lounge.
● People's rooms were personalised and contained belongings and items that were important to them. People said, "Just been asked to choose what colour I want my room decorated" and "Able to bring my bits and pieces, my son got me a new TV and the maintenance guy set it up for me straight away. I have got some of my painting hangings hanging up in my room and along the corridor."
● The service also had outside space which was accessible to people who used the service. The garden had an aviary in which people told us they enjoyed looking at. One person liked to feed and look after the birds.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of people's needs had taken place after people had moved to the service. This meant that there had been some incidences of inappropriate or failed admissions. The new management team confirmed that plans were in place to carry out a detailed assessment prior to people's admission. This included when people had been in hospital. This will enable them to identify care and support needs and assess whether the service was able to meet people's needs.
● Staff could explain people's needs and how they supported them.

Staff support: induction, training, skills and experience
● Staff told us they had received supervision meetings with their line manager to support their development. The operations manager told us that they and the training manager had just provided each member of staff a structured supervision session. The provider had put systems in place to ensure that the new manager (who was due to start employment) received support and structured supervision.
● The provider had developed a new induction programme which included a three-day induction course.
● Staff received training which was effective and gave them enough information to carry out their duties safely. Further training was planned such as fire safety training and fire evacuation on 06 February 2019.
● Further dementia training was going to be available. The operations manager told us they planned to have dementia champions in the service and then they will introduce dementia friends.
● People told us that they felt the staff had the right skills and knowledge to assist them. Comments included, "Initially new staff are a bit hesitant but soon get to know our needs by shadowing with the older staff. Above all they seem to have the right attitude when helping people" and "No qualms about the staff skills, when I am being hoisted one controls the hoist and the other gently moves me unto the bed."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
●We observed people being treated with kindness and respect by staff. Staff took time to talk with people and played games, which people enjoyed.
●People said they liked the staff and got along well with them. People told us, "Staff are all lovely"; "Staff very good and caring I have never seen anyone being treated any differently" and "They are all very caring, do what I want them to do for me. I would soon tell them if they didn't get things quite right."
● People's personal records were stored securely in the offices. Staff were respectful of people's privacy and knew to discuss confidential information behind closed doors and not in communal spaces.
● The atmosphere in the service was relaxed and calm. There was good interaction between staff and people with a lot of laughter, joking and banter.

Supporting people to express their views and be involved in making decisions about their care
● People were supported and treated with dignity and respect; they were involved in making decisions about their care and support.
● People were encouraged to express their views on how they preferred to receive their care and support.
● People told us they felt that staff took time to chat with them and listened to them. One person commented, "Staff often come in and sit down for a chat. I can talk over things that worry me with them." Another person said, "I cannot hold a pen anymore, I told one of the carers I wanted to send Christmas cards and they sat with me wrote out my cards for me and another carer helped me to wrap up my presents."
● People told us that church services were held at the service once a month and if they wished to attend they could do so.

Respecting and promoting people's privacy, dignity and independence
● People told us that the staff respected their privacy and dignity. We observed staff knocking on doors before entering rooms and closing the doors when they carried out personal care.
● People said, "Staff don't look down at you, they give you total respect" and "They close the door and curtains so people know they cannot come in without checking I am decent."
● People were encouraged to maintain their independence. We observed one person with visual impairment walking from their room to the dining room with the care staff walking alongside them. At lunch time when this person was given their lunch the staff member put the spoon on their plate and then told the person what side the spoon was on and stood beside them until they had it in their hand on the spoon before they left the person's side.
● Other people told us, "I am fairly independent I wash and shave every morning and get myself dressed. Whenever I fancy a shower I ask one of the staff to come with me" and "Staff very respectful of people's

wishes, they always tell you it is your choice of what you want to do, they don't try to dissuade you. I have a shower every morning and staff help me into the shower" and "When I have a good day, staff will help me get up and join the others in the lounge for a few hours."

● People were supported to maintain important relationships. There were no restrictions on visiting times and family members were free to visit at any time.

● People were supported to be independent. For example, a small kitchenette area had been created on the ground floor which enabled people to make hot and cold drinks.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
● Some care plans were in place. These were not always relevant and up to date to detail how staff should meet people's needs. For example, people's epilepsy care plans did not detail what type of seizures each person had how long the seizures usually lasted.
● People's diabetes care plans did not detail what each person's normal blood sugar levels were and what staff should do if the blood sugar levels went over that.
● People's care plans were not updated as and when their needs changed. One person's care plan did not reflect that they were now cared for in bed and had increased needs with their personal care.

The failure to adequately plan people's care and treatment was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were knowledgeable about people and their care and support needs.
● People told us that they had regular reviews of their care and support needs. Comments included; "My key worker discusses my care plan with me. I speak my mind when it comes to what help I need and what help I want from the staff" and "Reviewed by my key worker, last time we talked about my wishes for my funeral."
● A two weekly activities planner in text and an accessible format was displayed in several areas of the service. The activities staff member was undertaking training so planned activities were cancelled. However, games were available for people to use, these were large enough that people with restricted movement could use with ease.
● People told us, "I just love painting and have now got a suitcase full of finished pictures, the activity lady gets me to choose my next painting books on line and gets them sent here for me"; "Lots of activities, bingo, films, been to the pantomime. We now have a karaoke machine and words are shown on the television screen. I did the singing and held the microphone for others to sing, its great fun" and "I am partially sighted and like to listen to my talking books. I borrow books from RNIB (Royal National Institute of Blind People), the staff read out the titles from a list and I choose which ones I want and they order them for me and they are sent to the home. When we play bingo one of the staff helps me do my cards."

Improving care quality in response to complaints or concerns
●The complaints policy in place which was also available to people in a pictorial format. The complaints procedure was displayed in the service.
● We were unable to review complaints information and whether complaints had been dealt with because any records before January 2019 were missing. The management of the service had changed and the new management team were unable to locate the records. This is an area for improvement.
● People who could communicate told us they knew what to do if they had a complaint, and the people they could speak with about this.

● People said, "I complained that one of the door locks didn't work; it was repaired straight away"; "[Name of manager] and owner listened to my concerns about people smoking in their rooms, they put smoke alarms in these rooms, seems to have worked people now tend to go outside to smoke"; "People were banging on our doors trying to borrow things, I spoke to the manager and [provider], they spoke straight away to the people and the issue stopped"; "I would speak to the manager or owner, they often pop in" and "No complaints on anything, everything is fixed as soon as you mention it."

End of life care and support

● Some people had some plans in place for their choices at the end of their life. However, there was only one person living at the service that was reaching the end of life care stages. The provider was proactively engaging with health and social care professionals to ensure that the person had any equipment and medicines to ensure that they were comfortable so they could ensure a dignified and comfortable death.

● Six staff had attended death and dying training to increase their knowledge of end of life care. However, the training records did not record staff training at previous employment in end of life care.

● Staff ensured people were supported at the end of their lives. One person was in hospital during the inspection, they had no family. The hospital had contacted the service and advised that there was no further treatment available and the person was likely to pass away that day. Staff members went to the hospital to be with the person and to ensure the person was not alone in their final moments.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 06 February 2018, the provider had failed to effectively operate quality monitoring systems and processes to improve the service.

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Continuous learning and improving care

- Records were not accurate, complete or contemporaneous. Many files and records were missing and could not be located at the service. Records of people's care were poor. Some days entries had been made to detail the care provided, other days were missing. For example, one person's daily records were missing for 27, 28, 29 of January 2019. Another person who had unstable mental health at the time was missing records for 20 January 2019.
- One person was having their fluid intake and output monitored. The person's records were incomplete, inaccurate and confusing. This meant that their fluid intake and output could not be effectively monitored.
- There had been no audits or checks of the service completed since our last inspection by the manager. The provider had found this out through instructing an external consultant to carry out a review and audit of the service.
- The provider had arranged for the operations manager to carry out a comprehensive audit of the service and develop an action plan. This was carried out before we inspected and a copy of the action plan was given to CQC. The provider advised that they would send a monthly report to CQC to update the actions outstanding by the last working day of each month.

The failure to store securely and complete, accurate and contemporaneous records and failure to effectively monitor and improve the service was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had not effectively monitored the service to ensure that managers in post were carrying out their roles effectively. This meant that the quality of the service had deteriorated. Many of the previous improvements had been undone.
- The provider told us that they had learnt lessons from this. They had implemented a new staffing structure and recruited a new manager who was due to start on the 04 February 2019. They had put support in place to ensure the new manager received effective support, supervision and assistance to improve the service.
- The provider had not always notified CQC about important events. One person sustained a serious injury in 2018 which had not been reported.

The failure to notify CQC without delay of incidents was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were invited to regular 'resident's meetings' where they were asked their opinions about the service. People's feedback had not always been acted on. For example, one person had reported during a meeting on 13 January 2019 that they were not happy with two staff as they felt they had been treated like a child, and they didn't get to choose own clothes. This had not been passed on to the management team or investigated.

The failure to act on feedback from people demonstrates a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other people provided positive feedback; "At resident's meetings we are asked for suggestions and any problems. I suggested that we had no where we could hang our coats, now got a bracket with five hooks on it"; "At the meeting we discussed having a new kitchen area in the lounge where we could make our own drinks, now it has been completed it gets well used, we can prepare our own breakfast, make our own toast and drinks" and "When I was asked about the menu I said they cooked too many fried dishes, now we often have curries and a choice of baked fish or fried fish on Friday."

● People were engaged in the service and asked their opinions. The home operated an open-door policy where people, relatives and staff could give their opinions about the service and share their views at any time.

● The provider was in the process of gaining feedback about the service. Questionnaires had been sent to people who used the service and their relatives. At the time of our inspection the provider was reviewing responses they had received. Four relatives had responded with positive feedback.

● People, relatives, visitors and staff knew about the rating and findings from previous inspections. The rating and a copy of the report was on display in the service and on the provider's website.

● Staff meetings had taken place intermittently. Plans were in place to improve communication.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● There were established processes and procedures in place to ensure people received care and supported they wanted.

● The management team and provider said they had an open-door policy so that people, relatives and staff could raise any issues or concerns or make suggestions. The management team understood the duty of candour requirement to be honest with people and their representatives when things had not gone well.

● People told us, "The new manager starts Monday, able to talk to the any of the staff they all listen and get things sorted out straight away" and "Looking forward to the new manager, the last one tried to make too many changes at once, always willing to listen and discuss ideas."

Working in partnership with others

● The provider had engaged with other providers and registered managers at forums held by the local authority and external organisations.

● The operations manager told us they planned to link in with forums and events to support the new manager in their role.

● The service worked closely with other health and social care professionals to ensure people received consistent care.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC without delay of serious injuries that had occurred. Regulation 18 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to plan care and treatment to meet people's needs and preferences Regulation 9 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the safe management of prescribed medicines and failed to take appropriate actions to mitigate risks to people's health and welfare. Regulation 12 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective quality monitoring systems and failed to ensure records were accurate and complete. Regulation 17 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate effective recruitment procedures. Regulation 19 (1)(2)(3)