Angel Healthcare Limited

Abbey House Residential Care Home

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Abbey House provides accommodation for up to 23 older people. The service is intended for older people, who may be living with a physical disability, sensory impairment or a dementia type illness.

This inspection took place on 4 and 6 October 2016 and was unannounced. There were 18 people living at the home at the time of the inspection.

We last inspected this service on the 28 November 2013 and found that the service was meeting the requirements of the regulations we inspected at that time.

The service did not have a registered manager in post; the last registered manager left the service and de-registered with the Care Quality Commission (CQC) in April 2015. A new manager had been appointed in August 2015 and was in charge of the day to day running of the service and managing staff. The manager intended to register with the Care Quality Commission but at the time of the inspection an application had not been submitted. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives said overall Abbey House was a safe place. One person said, "I feel safe here...no one is horrid..." However, we found some shortfalls that could potentially impact on people's safety and well-being.

Not all aspects of medicines management were safely dealt with. However most people received their prescribed medicines when they needed them.

There were not always enough staff to meet people's individual needs. Staffing arrangements were not flexible to provide additional cover when needed, for example, during staff sickness and holidays.

Menus offered a balanced and varied diet for people; however the majority of people did not like the food. The manager and registered provider were aware of people's views in relation to food and additional tasting and menu planning sessions had been arranged.

Not all risks relating to people's care and support had been identified and responded to in a timely way. Guidance to show staff how best to support people whose behaviour may challenge them was not up to date and did not always reflect people's needs.

People were complimentary about staff's approach and manner. They said staff were kind and caring. A relative said, "The staff are delightful." However, staff did not always maintain people's privacy and confidentiality.

Staff completed induction training when first in post which was based on nationally recognised standards and they spent time working with experienced staff to build their confidence and competence. Various training was provided for staff related to their roles. However, not all staff had completed the relevant training to ensure they had the ability to meet the more complex needs of some people. For example, how to manage long term conditions such as diabetes; or manage behaviour which may challenge the service.

The provider did not have effective quality assurance checks in place to monitor the quality of the service and drive improvement. The provider had not identified the areas for improvement we noted during our inspection. Staff felt the service was well-run by the manager and provider and said there had been improvements at the service since the manager was appointed. People felt the management team were approachable. The manager was aware of many of the areas which needed improvement. A deputy manager had recently been appointed. They would be assisting the manager with the running of the home.

People, or their representatives, were not routinely involved in planning and reviewing their care. Personalised care was not always provided as some people's care plans were out of date or contained inaccurate information. However the manager and staff were aware of people's care needs, which reduced the risk.

Staff understood their responsibility to protect people from the risk of abuse and were confident the manager and provider would act on any concerns.
People knew how to make a complaint. They said if they had a problem or concern they would speak with the manager or staff. Relatives also knew how to make a complaint. Complaints had been investigated and resolved by the manager.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff to meet the needs of people who used the service.

Risks to people's health and safety were not being adequately identified and addressed in a timely way.

Not all aspects of medicines were safely managed.

Staff had a good understanding of safeguarding and how to report concerns.

Most aspects of staff recruitment were safe and ensured people were protected from unsuitable staff.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the MCA were followed and staff obtained people's consented to their care before they provided it. However, not all staff understood the principles of the MCA as they had not received appropriate training.

Parts of the environment were in need of refurbishment.

The meals offered were varied and nutritious but the majority of people reported they did not like the food on offer.

People were supported to access other health care services whenever this was required. However, recommendations from professionals were not always implemented in a timely way.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were caring towards people and we observed positive interactions with some staff. However, staff did not always have sufficient time to interact with people except when receiving

care.

Staff did not always maintain people's privacy and confidentiality.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Some care plans lacked up to date information about people's needs, meaning staff did not always have the information they needed to provide personalised care.

Activities for people were limited and care staff did not have the time to support meaningful activity at the service.

Complaints had been taken seriously by the manager and had been resolved to the satisfaction of the complainant.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager at this service. A manager had been appointed but had not submitted an application to be registered.

The provider did not have an effective system for monitoring the quality of the service and driving improvement. Records relating to the care and treatment provided to people and running of the service were not always accurate or up to date.

People and their relatives said the management team at the service were approachable.

Abbey House Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 4 and 6 October 2016. This visit was unannounced and the inspection team consisted of one inspector, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked at previous inspection reports and other information about the service including notifications. Statutory notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. Before the inspection, 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 looked at the information in the PIR. We considered information which had been shared with us by the Local Authority and looked at safeguarding alerts that had been made. We also contacted a Local Authority commissioner prior to the inspection to obtain their views about the care provided by the service.

During the inspection we looked around the service and observed the way staff interacted with people to help us understand the experience of people who could not talk with us due to living with dementia. We met with the majority of people living at the service and spoke with ten people. We spoke with one relative and four visitors, including a hairdresser and entertainer. We also spoke with two visiting healthcare professionals during the inspection and four health and social care professionals following the inspection. In addition, we spoke with the registered provider, the manager, five care staff and two ancillary staff.

We looked in detail at the care records and daily notes of four people with a range of needs. We looked at some policies and procedures in relation to the operation of the service, such as the safeguarding and complaints policies, audits and quality assurance reports. We also looked at three staff files to check the service was operating a robust recruitment procedure, and that staff received comprehensive training and regular supervision and appraisal.

Requires Improvement

Is the service safe?

Our findings

People, who were able, said they felt safe at the service. Comments included, "Yes I feel safe with regards to fire safety, things like that. Staff tend to come quickly when I call them..."; "Yes, I definitely feel safe in this place. The staff are totally trustworthy, I've never lost anything" "I think I would find it hard to find a better place" and "Yes, I do feel safe… I've never had abuse and shouting." One person said "I feel safer with my door locked. Sometimes residents wander around and come into my room and I feel a bit unsafe."

We received mixed comments from people when we asked if there were always enough staff on duty to meet their needs. Eight of the ten people we spoke with said they thought the service was short staffed at times. Comments included, "I think they are short-staffed"; "If I call for help, they usually come to me quite quickly, as long as they are not busy. The staff are always very busy with all the residents"; "Sometimes they are not quick at responding to my calls for help" and "There are shortages of staff, no cook and no activities lady…" Another said "Busy here at tea time, but better than in hospital".

Some people described waiting for 10 or 15 minutes for assistance, especially at busy times in the morning and evening, when people were getting up or ready for bed. One person said they had waited 50 minutes recently for assistance. This was discussed with the manager and registered provider. The manager was not aware of any incidence where a person had to wait more than a few minutes for assistance. However there were no arrangements in place for monitoring response times of the call bells.

During the first day of the inspection one staff member had called in sick. We observed staff were busy and had little time to spend with people except when assisting with their care needs. One person said, "The staff are nice but they don't have time to chat. They are very busy…" One person regularly called out to staff and became distressed. They were often asked by staff to "wait a minute". When staff sat with the person they became calmer and relaxed and stopped calling out. However staff were not always able to sit and reassure the person. One member of staff said, "We can manage with three staff and the manager in the morning but when people are sick it can be difficult but we try to manage." Two people described changes to the staff team over recent months and explained the changes had been unsettling for them. One said, "The old staff were very very good. I don't know the new ones so well…" Two people also commented on the use of agency staff to cover the night shift. One said, "Sometimes we have bank staff at night and they don't know the residents". Another commented, "I don't like it when we get agency staff. They don't know what to do."

The manager confirmed the preferred staffing levels were three care staff; one housekeeper and the manager for the morning shift (8am to 2pm). The preferred staffing for the afternoon/evening (2pm to 8pm) shift was confirmed as two care staff and one housekeeper and the manager until 5pm. Two waking staff were on duty at night. Care staff were responsible for doing the laundry at the service. This meant they had less time to spend with people, responding to their requests or engaging them in social activities.

We reviewed the staffing rota for September 2016. We found the provider's preferred staffing levels had not been maintained on five occasions during the day in September 2016. The manager explained that two of these shifts had been covered by other members of staff but this was not recorded on the rota.

The registered provider explained that people may have found delays in responses during August 2016 due to staff leave. Due to the short notice sickness on the first day of the inspection cover had not been found, so the team were one member short for the early shift. We found staffing arrangements were not flexible to provide additional cover when needed, for example, during staff sickness and holidays. The manager explained there were currently two staff vacancies at the service which were "continually" being advertised.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they received their medicines as needed. One person said, "They give me my medication and they watch me take it". However, some aspects of medicines management were not safe.

There were discrepancies in the records relating to one person's insulin dose, with the care plan stating one regime and the medicines administration record (MAR) stating another. The manager confirmed the correct dose was stated on the MAR. By the second day of the inspection the manager had contacted the GP who had agreed to create a plan of care for the management of the person's diabetes. A GP told us in their experience some staff did not fully understand the management of diabetes, which posed a risk. However, they added the service did contact them when there were concerns about the person's blood sugars, which meant the person could be monitored and doses adjusted.

Not all staff administering insulin had been trained by a suitably qualified person to ensure their competency. Seven staff who had received training from a diabetes specialist nurse had not had their competency checked since the original training in November 2014. We saw certificates for five of these staff members. Two members of staff had not received any external training. One staff member who was responsible for administering insulin told us that they had been shown how to do this by another senior care worker. According to the guidelines for managing medicines in care homes issued by National Institute for Health and Care Excellence (NICE), "Care home providers should ensure that all care home staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines". There had been one error in relation to the administration of insulin, and records showed the manager had dealt with this through the disciplinary process.

One person had been assessed as able to manage some of their own medicines, however secure storage was not available in their room. The medicine was kept in a bedside drawer which was not lockable, which could pose a risk to other people.

Out of date medicines were being stored, which the manager disposed of once brought to their attention. Creams, which had a limited efficacy once opened, had not been dated to ensure they were not used past their 'best before date'. Where staff had handwritten entries onto the medicines administration records, these had not been signed by the member of staff responsible or countersigned by another to ensure accuracy and accountability.

Medicines were stored securely but not always at the temperature recommended by the manufacturer. The temperature of a cupboard used to store medicines was not being monitored. We used a thermometer to assess the temperature and found it was over 26oC, above the recommended temperature of 25oC. The manager took immediate action to address the issue by using a fan to reduce the temperature. By the second day of the inspection the temperature within the cupboard had reduced to 24oC.

People were not always protected against risks in a timely way and timely action had not always been taken to prevent potential harm. One person had been identified as being at risk of choking. A referral had been

made and the person was seen by a speech and language therapist (SALT) and recommendations had been made to keep the person safe. However, these recommendations were not incorporated into the person's care plan initially. A SALT expressed concern about this and explained to us that although they were not aware of any harm caused as a result, not having the up to date advice placed the person at risk. The manager explained the SALTs initially recommendations had not been received by the service. A second referral was made in September 2016 and additional recommendations were made to ensure the person was safe when eating. Copies of these recommendations were on file, they had been incorporated into the person's care plan. Staff on duty supervised the person during mealtimes as recommended by the SALT, which reduced their risks.

Another person displayed behaviours which could challenge staff and earlier in the year a safeguarding alert had been made in relation to this person and the way a member of staff had responded to them. Five of the 13 care staff had received training on 'Coping with Aggression', meaning some staff may not have the confidence and skill to support people whose behaviour may present a challenge. The care plan and risk assessment for this person lacked detailed guidance for staff to follow to help them understand what might trigger the behaviour and how best to reassure and calm the person. During the inspection we observed this person became anxious and called out throughout the morning. The person was not engaged with any activity, which might distract them or keep them busy. When staff had time to spend with the person they were reassured and calm but staff did not have enough time to spend more than a few minutes. Following the inspection the provider wrote to us confirming individual risk assessments and care plans in relation to behaviours had been up-dated.

The service was unable to monitor people's weight who were not fully weight bearing because suitable scales were not available within the service. The manager explained staff had not been trained to undertake body mass index assessment, which would be another way of monitoring a person's weight loss. We spoke to a speech and language therapist and GP about two people. They confirmed both people were small and that they did not have immediate concerns about their weight. However, the service had no effective way of monitoring the risk of potential weight loss.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said staff helped them manage any pain well with medicines. Comments included, "They give me paracetamol for pain" and "I do get painkillers."

People's allergies were recorded on the MAR and there were protocols in place for the use of 'when needed' medicines. There were no gaps in medicines administration records, which indicated people received their oral medicines as prescribed. Cream charts were used to confirm the administration of topical medicines. These were generally completed with one or two gaps seen. Medicines which required additional secure storage were kept safely. The stock balance for these medicines tallied with the relevant records. Unused medicines were disposed of safely.

The service had a medicines policy which covered the basic principles of safe medicines management. However, they did not have a copy of the NICE guidance and the manager was not aware of this guidance. The manager said they would obtain a copy of the NICE guidance and discuss this with the staff.

Written risk assessments were in place which identified individual risks, for example risk of falls or skin damage. Risk management plans provided staff with information about how to reduce potential risks. For example, one person had a high risk of developing skin damage. They had a special mattress on their bed to

reduce the pressure on their skin and this was set appropriately. Where people had been identified at risk of falls, guidance was available to reduce this. For example the equipment the person used or the support they required from staff to stay safe when mobilising.

Some aspects of fire safety were not well managed. Several fire doors were propped open with door wedges or furniture. We drew this to the manager's attention on the first day of the inspection. On the second day of the inspection, five fire doors remained propped open. This put people at risk of harm in the event of a fire. The fire risk assessment was dated April 2014 and did not contain up to date details about the service or people currently living there. The 'resident's fire record' used by staff was out of date and did not reflect the number of people living at the service. The provider emailed us confirmation that five new door-guards had been purchased and were to be fitted to the relevant doors by 17 October 2016. The provider also sent us up-dated copies of the fire overall risk assessment, which had been completed by a fire safety expert, and 'residents' fire risk assessment, used daily by staff. We made a referral to the local fire safety officer in order to provide advice and support to the service.

The hot water in communal bathrooms posed a risk of scalding people at it was in excess of the 44oC. Although this was being addressed on the second day of the inspection, the provider did not have effective checks in place to ensure water temperatures were safe.

People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. When people had accidents, incidents or near misses these were recorded and investigated. For example, one person had experienced seven falls in September, although no serious injuries had been sustained. The staff suspected the person had developed an infection and contacted the GP and obtained specimens for analysis. Staff had contacted the GP six times about the person's falls and their concerns. An infection was diagnosed and antibiotics prescribed. No further falls had been recorded following their treatment.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They were knowledgeable about the different types of abuse and the process to follow to report any concerns. They knew to inform the manager if they had concerns, or if not they would go to social services or the police. They confirmed they had received safeguarding training. The matrix for the training records showed that some staff had up to date safeguarding training, but for others they had been given booklets to complete earlier in the year. As yet, the matrix had not been updated to show if they had completed their refresher training or not.

There had been four safeguarding alerts made to or by the local authority in the past months; the manager made one of the alerts. The manager had worked in partnership with the local authority in order to investigate and address the concerns. Where necessary disciplinary action had been taken with staff and additional training had been undertaken to improve staff's understanding of behaviours they may find challenging.

The service had safeguarding policies in place and whistleblowing information was also displayed in the office detailing where concerns should be reported to. This showed that there were processes in place for staff to follow to minimise the risk of abuse occurring.

Staff recruitment records were in place. However, one risk assessment carried out for a member of staff's records was not available at the service. The manager explained the steps they had taken to make a decision about their employment. We did not see the records documenting the discussions that had taken place with the manager and the head office to verify this. Appropriate checks were undertaken before staff

began work at the service. Pre-employment checks had been carried out in two of the records we looked at, including reference checks from previous employers and Disclosure and Barring Service (DBS) checks. However, one DBS check had been received after a staff member had started work at the home. This was previous to when the current manager was at the service. All other records had been received before the staff member started work at the home. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The manager undertook audits to ensure that all recruitment records were in place.

Requires Improvement

Is the service effective?

Our findings

Some people said the staff were well trained and were seen to carry out their duties well. One person said, "The staff seem qualified to look after us…" Another commented, "The staff work very well".

Staff said they felt supported by the manager and they received training relevant to their role. One said, "The induction was brilliant, I couldn't fault the support. I shadowed other staff. All staff were welcoming and helpful to me…" They described undertaking a structured induction. Staff records and a training matrix showed staff received core training. For example, safeguarding; infection control, fire safety, moving and handling and managing medicines. Staff were about to attend practical manual handling training sessions at the local hospital. During the inspection some staff attended a medicines management training session provided by an external trainer. However, not all staff involved in the care and support of people living with diabetes had received relevant training to ensure they understood how to safely manage and monitor this condition. Not all staff had received training to help them understand and respond to behaviour which might challenge them. The manager explained they were trying to source additional practical training from local health care professionals. The manager confirmed of 17 staff, 10 had a national care qualification (NVQ) and 8 of them were doing more qualifications at higher levels.

Staff records showed staff received supervision and appraisals, which provided an opportunity to discuss their performance and training needs. Staff confirmed they received regular supervision with the manager. One said, "I meet with the manager and we talk about my work and how I am doing." Staff said the manager was approachable and they could speak with her at any time about concerns. A deputy manager was to take on some of the responsibility of organising training and supervision. Records showed that the manager was taking a very proactive approach towards ensuring staff were working according to their job descriptions and expected standards. Verbal and written warnings were in place where the manager felt a staff member was not working as they should. Clear expectations were made in their records; for example to ensure they followed the speech and language therapist recommendations.

We received mixed comments about the food at the service. Eight out of 10 people said they did not always enjoy the food. Their comments included, "The food's terrible. It changed this year, nothing is made here"; "The meals are vile. They taste of warmed up plastic. It (food) was really good when we had a chef. If they have enough time, they will do something else for me, as I refuse the meals"; "I don't like the meals here" and "I really don't like the food. My family bring me food." This person opened their bedside drawer to show us a store of biscuits, crackers and sweets. Another person said, "Food isn't as good as it was when I first came in". We observed that a few people left some of their meal.

Two people were happier with the food. They said, "I think the food is reasonable. They do me something else if I don't like what's on the menu" and "When I ask for soup for supper, I get it. They do pancakes for me sometimes."

Each day the housekeeper asked people what they would like from the menu. Breakfasts were prepared by the housekeeper. The housekeeper had a good knowledge of everyone's likes and dislikes. The main meals,

served at lunchtime, were provided by an external catering company. They were delivered frozen and the service had special ovens to re-heat the food safely. People's dietary needs were recorded. A variety of special diets were provided, including diabetic meals, and soft or pureed meals if required. In addition to the pre prepared meals there was also a variety of fresh and non-perishable foods available for people. In a store there were large supplies of fresh fruit, yoghurts, eggs, ham, cheese, and cakes. People had access to snacks and drinks throughout the day. Tea or coffee and biscuits were served in the morning and afternoon. Juices were available in the lounge all day and fresh water was in people's bedrooms.

The manager and provider were aware of people's views of the food as these had been expressed in a recent satisfaction survey. They were arranging for additional taster sessions with the catering company. They were also preparing to use addition satisfaction surveys especially for food.

The dining room experience was not relaxed or sociable. The radio was on loudly in the kitchen and staff were talking to each other in the kitchen, rather than ensuring people were welcomed and seated comfortably. We observed several people arrived 30 or 40 minutes before lunch was served. One person rested their head on the table and napped until roused by staff. One person said after being seated for 30 minutes, "I think I came in too early or lunch is late…" Another person told us, "There is not a relaxed atmosphere at lunch time." They said the majority of people did not use the dining room so it was rather quiet and unsociable.

People had access to health and social care professionals. Records confirmed people had access to a GP, speech and language therapy, occupational therapy, specialist nurses, chiropody services and could attend appointments when required. One person said, "I'm being visited by the chiropodist today and they would call the doctor if needed". Another said, "A dentist has visited and if I was not well, they would call the doctor". Staff said that they would take people to the GP practice or if someone was particularly unwell, the GP would visit the home.

We received mixed feedback from professionals about the staff's ability to manage people's long term conditions, for example diabetes or choking risks. A GP said staff were pro-active when people's health needs changed and they had regular contact with the service. However, they were less confident in staff's ability to understand and manage people with diabetes. The care plan for a person living with diabetes did contain information about how to respond should the person's blood sugar fall outside of the expected range. However, one staff member was not aware of this information. They said they would speak with the manager or senior on duty if they had any concerns.

A speech and language therapist (SALT) said they were not confident that their advice was always understood or followed. However, another SALT said they were confident the manager and senior staff understood and implemented their recommendations. A social care professional said they were not confident the service could deal with more complex people but that they managed people with low needs in a satisfactory way. They added, "They are a bit disorganised at times. Recommendations from professionals are not always followed (with regards to safe eating) and the paperwork is not always up to date." We found some care records were not fully up to date with regards to people's health needs. Following the inspection the provider wrote to us confirming care plans had been reviewed and up-dated.

A bowel and bladder nurse specialist said the manager made direct and appropriate referrals to them when necessary. They felt staff were knowledgeable and competent when completing bowel and bladder records needed for their assessment of people. They also confirmed their recommendations had been fully implemented. An occupational therapist confirmed they had received an appropriate referral when staff experienced difficulties assisting one person to move safely. They said senior staff were knowledgeable and

communicated well with the person during their assessment and understood the recommendations they were making.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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's wishes and preferences had been followed in respect of the care and support they received. The electronic care planning system prompted staff to consider people's capacity to make decisions and people's capacity to make decisions had been recorded. During the inspection staff involved people in decisions about their daily care. For example, where they spent their day; what they wore and what activity they engaged with. One person said, "They do ask permission from me before doing anything. The staff don't stop me doing things. I do feel involved in my care." Another person commented, "The staff are good as a rule…they make sure I am happy with what they need to do…"

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager had submitted one urgent DOLS application which was being considered by the local authority. The manager did not consider that any other people currently living at the service required an application to deprive them of their liberty.

MCA and DoLS training was provided to some staff who demonstrated a varying knowledge of the legislation. The manager was able to describe the purpose and principals of the Act whereas other staff were unclear of how they would follow appropriate procedures in practice. One urgent DOLs had been submitted to the local authority for one person, but one member of staff was unaware of this or the conditions relating to the DOLs application, which meant the agreed conditions could be breached. This member of staff had not completed any training to help them understand their responsibility. Following the inspection the provider sent us MCA and DOLS training certificates for six staff, which had been completed in 2016. However, seven staff had not received this training. There was therefore a risk staff would not follow the principles of the MCA and people's care may not be provided in the least restrictive way. Following the inspection the provider sent us confirmation that this training had been programmed in to staff's personal development plans. A full discussion and overview of the subject was to be put on the agenda for the next staff meeting to ensure staff had a basic understanding of the Act.

Parts of the environment were in need of attention as they were not well maintained or homely. The dining room had been redecorated and re- carpeted in August 2015 and one or two bedrooms had also been refurbished. However, the front entrance to the service from the street did not make a good first impression as the area looked tatty and overgrown. Some bedroom carpets were worn and stained as was some soft furniture. Parts of the stair carpet had begun to fray. The provider explained that white tape was used on the stairs to help guide people safely up-stairs and not to secure the carpet. There was an old foam pressure cushion in one person's rooms, which was stained and did not have a cover. The manager said this would be disposed of. We visited one person in their room. They had no light shade, just a bare bulb handing from the ceiling. They said, "They (staff) took the shade down to change the bulb and didn't replace. I have asked but as you see it hasn't been done…"

The manager had identified a number of improvements required within the environment and shared these with the provider in August 2016. This included areas which required deep cleaning; the replacement of

some beds; areas which required replacement carpets and areas for redecoration. There was an environmental improvement plan in place but no timescales were set. Following the inspection the provider sent us an up-dated business plan which showed environmental improvements were in progress; however there was no date for completion.

Requires Improvement

Is the service caring?

Our findings

We asked people their views of the service and what they thought of the staff who cared for them. People were generally positive about staff's approach and attitude. Almost all said the care delivered was good and most thought the staff were friendly, kind, caring, helpful and respectful. Comments included, "I can't complain about the staff. They are sweet and kind to me"; "Most staff are kind, but they don't have time for you. The male staff are good"; "One or two of the staff are smashing"; "I think there is a good mix of staff. The staff are very patient with me" and "The staff are lovely towards me. I am well looked after". Visitors told us "The staff are delightful. They are charming; absolutely, very patient".

People's dignity and privacy was not always respected by staff. We overheard staff discussing people private health needs and personal care needs in communal areas, within the earshot of other people. The manager showed us minutes from a recent staff meeting where staff were reminded about maintaining people's privacy and confidentiality. Following the inspection the provider sent confirmation to us that all staff would be reminded again. Staff could be loud at times in communal areas without thinking of the impact of the people around them. We observed staff talked to each other above people's heads while they were seated without involving the person in the conversation.

Some staff did have warm relationships with people, and engaged in conversation or shared a joke with them. One person said, "The staff are good, kind and considerate." However, we observed staff initiated conversations and social interactions with some people more than others. It was clear people benefited from social contact with staff, for example, they became more talkative or smiled more or their anxiety was reduced. However, not all people benefited from the same amount of staff social interactions and contact. Some people spent long periods in their bedroom with little interaction with staff. One person explained staff did not have the time to sit and chat with them. They said although they preferred to stay in their room and staff "popped in and out", they could feel lonely at times. Another person spent long periods of time sleeping in their chair during the morning; they were disengaged and had little staff contact except when staff were delivering care and support. However, when stimulated by music in the afternoon, they became more animated and tapped along to the music.

We witnessed several positive interactions between staff and people. On one occasion a person had become uncovered which impacted on their dignity. Staff gently covered the person and ensured they were warm and comfortable. When staff assisted people, for example supporting a person into a chair, staff treated them in a gentle supportive way and reassurance was given and staff explained to the person what was happening. People were supported at their own pace and were not rushed when being assisted to move safely. One person said "Generally, I am happy here. The best thing is the staff are kind. They always want to please us." Another person said, "One staff member buys my toiletries for me. One of the carers brought me a neck pillow and wouldn't take anything for it."

People said staff listened to them. For example, one person said staff supported them to get up and go bed when they chose to. Another person said staff were "obliging" and they felt able to confide in staff. They added, "When I am feeling unwell, they listen and call the doctor if needed." Another person said, "I do like

my own space. I like to look after myself. The staff are good to me."

People felt staff respected their privacy and showed respect to their own bedrooms. They felt staff respected their belongings. Comments included, "They respect my privacy"; "The staff are respectful, they knock the door if I'm in my room" and "When the staff deal with me privately, they are fine". Staff explained how they protected and respected people's privacy and dignity when assisting with personal care. Examples given were knocking on doors and waiting for permission to enter and closing doors behind them. They described ensuing people were covered during personal care to protect their modesty and making sure people were assisted to dress appropriately in clothes of their choosing.

People appeared well dressed and groomed and most were happy with the support they received to maintain their personal care. One person said, "I am independent, but they help me to shower. They would let me have a shower any time". Another told us, "They do help me dress and get me in and out of bed and help me shave." However one person commented, "I'm down to have two baths a week, but I only get one. I don't like the young ones attending to me."

People were consulted about the gender of care staff supporting them. Where people had stated a preference not to have male care staff supporting their personal care this was respected. One person said, "I choose not to have the male staff looking after me." Another person said, "I don't mind the male members of staff". A third person said the male care staff were "particularly good". They added, "We all get along. They are respectful." Another person commented, "All the staff are very polite."

We saw people's relatives and other visitors were welcomed on arrival at the service. People said there were no restrictions on their visitors. Comments included, "My family can visit at any reasonable time"; "If I had any visitors, they could come when they like" and "My family phone me and look after my affairs." The manager confirmed relatives and visitors were allowed to visit at any time without an appointment, unless restrictions had been agreed through the provision of the Mental Capacity Act and Deprivation of Liberty Safeguards.

There were processes in place to consider people's end of life wishes. One person told us, "I have signed a Do Not Resuscitate. They keep asking me if that is still my choice. I want to die here". A Do Not Resuscitate document records people's wishes about the treatment they want to receive should their health deteriorate. However, some care plans lacked detail in places to ensure people's wishes could be met. For example, information about where the person wanted to be cared for should their condition deteriorate had not been recorded for some people. Where people may have been asked about their preferences and chosen not to discuss these issues at the time, this had not always been recorded. This meant their wishes regarding treatment and end of life care may not be met as per their wishes.

People had access to information about the services offered at the home, activities, daily menu and the complaints procedure. Regular 'resident's meetings' were held and provided an opportunity to share information with people and for people to share their views and ideas. The agenda was advertised before the meeting and copies of the minutes were displayed in the dining room and on the top floor of the building. One person explained, "I do go the residents' meetings and I think they tackle things". Another person said, "The staff do give me the information I need." Another said, "If there is anything I need to know, I only have to ask the manager or staff."

Requires Improvement

Is the service responsive?

Our findings

Not all people or their relatives were involved in developing their care, support and treatment plans. Some people said they were aware of their care plan and that their care needs had been discussed with them. One person said, "They do involve me in certain things about my care." Another commented, "They speak to me about the care I need. Make sure I am happy. I think that is in a care plan." A third said, "They do review my care plan from time to time." However three people were not aware of their care plan and had not been involved in reviews of their care to ensure they were happy with the support they received. Comments included, "I'm not aware of my care plan and I've not had any reviews" and "I don't know what that is (care plan). I haven't seen one." This meant people had not always been consulted about changes that may be required to their care or had an opportunity to agree with the changes.

The manager explained prior to people moving to the service; she met with them and completed a 'pre-admission assessment'. We looked at two for people most recently admitted to the service. There was a pre-printed format; however neither assessment had been fully completed. For example both personal profile pages were blank, as was information about social and leisure preferences; and medical history. However, this information was contained in people's care plans, which were completed once people were admitted to the service.

The service used electronic care planning records and each person had a care plan in place. Some care records were more detailed than others and showed good histories had been taken of people. Levels of needs were clear, for example, where someone had very complex needs they had been assessed as 'very high dependency needs'. Night routines were clear, describing all care that needed to be given to support them. One person's care records showed their interests, such as tennis and football. Some care plans had been reviewed. However, one person's care plan showed their diabetes was controlled by diet when it was controlled by insulin. Also the instructions for using glucose to mitigate low blood sugar levels were not in the care plan. This meant some staff may not be aware of what to do in an emergency. Following the inspection the provider wrote to us to confirm that care plans had been reviewed and up-date with accurate information for staff to follow. The PIR stated the manager would review all of the care plans over the next 12 months to ensure that they were "practicing person-centered care and that the residents and their family involved in planning their care".

The majority of staff did have a good understanding of people's needs and could describe care needs well. They received updates about each person during the daily shift handover and also if they had been away from work on days off or on leave. Staff said they enjoyed working at the service. On the first day of the inspection, a member of staff stayed beyond the end of their shift in order to support the afternoon staff, which showed their commitment to people using the service.

People felt the care provided was individual and focused on their needs. Care records contained some information about people's preferred routines and people said their preferences were generally met. Comments included, "I get all the help when I require it"; "I do feel I get the care I need" and "Yes, I do think I get the care I should." One person confirmed their choices were met. "I go to bed early as I want to. I get up

at nine, when I want to. I have a shower or a bath; I can choose". Another person felt routines were not always responsive and they described delays at times when requesting assistance getting ready for bed in the evening.

Activities at the service were limited as the activities co-ordinator had been away from the service for some time. Activities were identified in the most recent 'residents' surveys as requiring improvement. One person said, "We had an activities lady, but she had to give up". Another told us, "There is nothing happening here really. It can be boring and the day can seem long…" Other comments included "There has been very little going on. In two months the van hasn't gone out." The manager explained the minibus used by the service was in need of repair and had been unusable for several weeks. This meant people had limited opportunities to enjoy any activities outside of the service. One person said, "A man comes in to sing songs and a lady comes in to do physical activity in chairs. Not many residents come down for the entertainment". The manager was aware this was an area to improve and was planning on introducing activities every afternoon.

During the first day of the inspection an external musical entertainer visited the home. Three people were involved in the session and thoroughly enjoyed themselves. In the diary there were records of five trips out in May and July. These had been to a local supermarket, to a fish farm, and the others to the seaside for coffee. One staff member confirmed there was a keyworker system at the service and this meant they had an additional hour each month to spend time with people. They might do their shopping for them or take them out. One person told us, "I get out with a carer to buy things for myself".

A hairdresser visited the service regularly and several people said they enjoyed this activity. Representatives from the local church visited at seasonal times and one person said, "The church minister visits me."

Some people reported they preferred their own company and stayed in their rooms. Three people said they were not concerned about the level of activities as they preferred to be in their room, watching TV, listening to the radio or reading. One person said, "I prefer my own company, so I don't take part in anything". Another person said they received 'talking books' from the blind organisation, which they enjoyed very much.

The provider had a complaints policy which was displayed within the service. People said they knew how to make a complaint or raise a concern and felt comfortable to do so if required. They were confident they could speak with the manager and she would listen and take action. One person said they had complained about the attitude of one member of staff and they no longer worked at the service. Another person said "I've never complained. I've got no complaints about anything". Other comments included, "I've not had any reason to complain"; "Apart from the food, I've nothing to complain about" and "I have no complaints, but I would complain if needed".

One relative said they knew how to make complaints. They said in the past they took an issue to the manager and this had been resolved. The manager said they took any complaints seriously and investigated them. Two complaints had been received in the past 12 months. These had been investigated and resolved by the manager.

Requires Improvement

Is the service well-led?

Our findings

The service had been without a registered manager since April 2015. A manager had been appointed in August 2015 but was yet to submit their application to be registered. The provider visited or contacted the manager daily to provide support and guidance.

People using the service knew who the manager was and they said she was approachable. Comments included, "The manager is a hard worker and is a very caring person. In general, the Home runs well"; "She is a brilliant manager, she has people skills and easy to approach"; "The manager is nice, she makes me laugh" and "The manager is busy. I'm on good terms with her, I can talk to her. The management is good here, it's OK. The main good thing here is the general atmosphere…" Two people said they found the manager's approach to be "loud". One added, "The Home on the whole is lovely. The owner is always at the end of the phone."

A visiting health professional and staff said overall improvements had been made at the service since the appointment of the current manager. One professional said this was evident in the records they required to make their assessments. They added, "There is more continuity and it is noticeable how she speaks with staff and service users. She generates respect." A visitor said, "Things have improved since the new manager came. The staff like the manager. The residents seem to like being here. I go to other Homes and this isn't too bad compared." Staff also commented positively about the manager's approach. One member of staff said, "(The manager) has brought this place right up since I started. The quality of caring is better. Things have been good since she came here."

The systems in place to assess the quality of the service provided or to monitor and mitigate risks to people were not fully robust or embedded. The provider had an established quality assurance systems but the manager had not fully implemented this effectively due to time restrictions. They planned to delegate some of the auditing responsibilities to senior staff.

Some audits were carried out; however these were not effective in bringing about improvements. For example, environmental audits completed by the manager had identified needed improvements, but these had not been actioned. Other audits for example medicines audits, had been carried out but failed to identify the shortfalls founds at this inspection. This meant that, should issues arise with medicines management, action had not been taken in a timely manner. A 'care overview' audit completed in January 2016 looked at aspects of care records, accident audits; activities and staffing levels. This showed areas for improvement still to be achieved. For example, ensuring monitoring charts were completed for weights; ensuring relatives were involved in care planning and reviews (where appropriate) and ensuring staffing levels were consistent to meet people's needs. We found these issues had not been fully addressed. The provider did not have effective checks in place to ensure water temperatures were safe.

The service had a business plan which had been reviewed in June 2016, which covered various aspects of the service. For example, infection control; health and safety; training; and long term goals. Outstanding issues were described as 'on-going' or 'in progress'. Therefore, there were no timescales set for achieving the

identified improvements where these were still to be achieved.

The provider had not ensured all records relating to the service were accurate, complete and up to date. This included records relating to the care and treatment provided to each person.

There had been no analysis of the falls that had occurred to try and detect any patterns. There had been a number of falls in the past 12 months. Staff had taken action in the immediate aftermath of each fall, however there had been no overall analysis to help understand why the falls had happened and if anything could be done to reduce the risk of similar incidents happening again.

The provider had not ensured people were protected from varying staffing levels. The provider's preferred staffing levels were not always achieved, which resulted in people reporting delays in receiving the care and supported they needed. Staffing levels were identified by people as area for improvement. Comments included, "One or two more staff could be an improvement"; "Not so good is they could have a bit more staff" and "The main problem here is the shortage of staff. This place is not running well because of the staff shortage".

The lack of robust quality assurance processes and risk management measures meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The PIR indicated some of the improvements planned over the next 12 moths. This included ensuring all audits were carried out on time and actioned appropriately and monthly audits were to be undertaken across all outcomes. A cleaning and infection control audit had been completed of all bedrooms in June 2016 and records showed the majority of recommendations for deep cleaning and minor repairs had been achieved. A quality monitoring visit had been completed by East Sussex County Council in September 2015, which identified a number of required improvements. These included aspects of people's care records and nutritional needs information; staff training and training records. At a follow up visit in March 2016 the County Council found issues had been addressed in a satisfactory way.

The provider and manager sought the views of people who used the service. People told us, "Once a month there is a resident's meeting and they do listen and mostly they do something about it"; "I do have my say and they act on things" and "I attend the meetings. We talk about activities and the food. The food hasn't improved though." One person said, "It's a waste of time having residents' meetings". They felt issues such as staffing had not been addressed. Another person commented, "I am very accepting of the situation here. They are very caring, that's the best thing here".

Annual satisfaction questionnaires were used to obtain people's feedback about the service. Results from the latest survey completed in June 2016 showed the majority of people rated the overall service as good. The highest satisfaction rates related to people feeling safe and listened to. The lowest scoring outcomes related to food and activities. Comments we received from people about improvements they would like to see at the service included, "If anything could be improved, I wish the meals could be cooked on site"; "The only thing I don't like about this Home is the ready-made meals" and "The improvement I would like to see is having a cook". The provider and manager were aware of these issues and had described plans for improvement. This included ensuring activities were offered every afternoon and organising a 'taster' sessions with the company supplying the chilled meals.

Annual surveys were also sent to staff. Results from the June 2016 survey showed staff enjoyed working at the service and the majority were satisfied with the training and support offered to them. Where one member of staff had raise a concern, for example about training, this was discussed at a subsequent staff

meeting where all staff were reminded that external training were available.

The manager was aware of the requirement to inform the Care Quality Commission of events or incidents which had occurred at the service. The commission had received appropriate notifications, which helped us to monitor the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety were not being adequately identified and addressed in a timely way. Regulation 12(2)(a)(b). People's medicines were not safely managed or consistently administered as prescribed. Regulation 12 (1)(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were a range of audits to monitor and assess the quality of the service. However these were not fully effective, as shortfalls were not being addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to meet people's individual needs. Staffing arrangements were not flexible to provide additional cover when needed, for example, during staff sickness and holidays.