Sira Care Home Limited

Garlinge Lodge Residential 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

We held an unannounced comprehensive inspection at Garlinge Lodge Care Home on 20 and 23 November 2018.

Garlinge Lodge is a privately owned residential care home for older people and people who are living with dementia or physical health needs. The service is registered to accommodate up to 14 people in one adapted building. The care is provided over three floors and people with the highest levels of dependency were on the ground floor. People had access to a toilet on each floor and a bathroom on the ground and upper floors. There was a dining room, lounge and conservatory on the ground floor with a lift for people to access from all floors.

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. Over the course of the inspection 13 people were provided with accommodation and personal care.

There was a registered manager in post. 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.

At our last inspection on 21 September 2017, the service was rated 'Requires Improvement' overall and in all the key areas. There were eight breaches of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. The provider had failed to ensure that people had personalised care plans that addressed all their individual needs; people's rights to privacy and dignity were not always upheld; the principles of the Mental Capacity Act 2005 (MCA) were not consistently followed when seeking consent from people to care and treatment; risks within the premises had not been assessed and managed to ensure people's and staff safety; medicines were not always managed safely; premises were not properly maintained and suitable for the needs of people living with dementia; there were not always effective systems in place to monitor and improve the quality and safety of the service and there were not enough staff to ensure staff could work in a safe way when caring for people.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve all the key questions to at least good. At this inspection although there had been some improvements, there were three continued breaches of regulations and one new breach of regulations. This is the third consecutive time therefore that the service has been rated as Requires Improvement. You can see what action we told the provider to take at the back of the full version of the report.

Since the previous inspection the registered manager had ensured staff no longer routinely worked long

hours and had made some changes to improve staffing levels. However, there continued to be insufficient staff to ensure people's needs were met and they were kept safe, as people were at higher risk of falls when staffing levels dropped. People and relatives thought they were kept safe. One person said, "I felt anxious living alone, I am happy here…I feel safe, I have had no falls…there is always someone about."

Action had been taken around the concerns we raised at our last inspection for risk management within the premises. However, there were further instances where people were not kept safe from environmental risks, to include cleaning chemicals not stored safely and no risk assessments for portable electric radiators. Other environmental risks such as fire, legionella and food hygiene had been managed and all the expected health and safety certificates were in place. Some refurbishment had been completed to improve the environment for people with dementia although further improvements were needed.

Assessments were person centred and included the needs of people. However, people's needs were not always assessed in detail before moving into the home. Risk assessments had not always been completed in a timely manner and were not in place for all risks identified. These were missing for people around their risk history of epilepsy and urine infections.

There had been some improvements to the providers systems to manage quality and safety. However, the registered manager did not always have good oversight of the quality and safety of the home. Risks were not always clearly understood and managed and accurate records were not always maintained. Care records were disorganised and not always legible. Some records were not always complete or kept up to date and some records held conflicting information. Internal audits were completed to check compliance, however continuous learning was not always evident. There were missed learning opportunities from accidents and incidents analysis. Falls analysis had not identified trends and patterns and audits had failed to identify the concerns we found. Relatives and staff thought the home was well led. One relative said, "They are very on the ball, it's reassuring. I think (name) is really good as a manager."

Medicines were now managed safely and people continued to be safeguarded from the risk of abuse. Safe recruitment processes were carried out by the provider. People were protected from the risk of infection and were cared for in a clean environment.

The provider was now working within the principles of the Mental Capacity Act 2005 (MCA) and where needed, people had a DoLS authorised or they had been applied for. People's needs were met by the homes facilities and people had specialised equipment, for example around their mobility.

Staff were knowledgeable about people's needs, had the right induction, training and on-going support to do their job. People were supported to eat and drink enough to maintain a balanced diet. One person said, "The cook comes and asks me what I want and gives me a choice, I have water in my room, no complaints… I'm having chicken today and something lemon for pudding which is up my street." People were supported to access the healthcare they needed. The provider worked with other health professionals to ensure people received the care they needed and that they were supported with various health conditions.

Peoples' rights to privacy and dignity were now respected by staff. People's independence was promoted by staff and appropriate systems were in place which ensured information held about people was secure.

The general atmosphere in the home was caring. We observed caring interactions between staff and people enjoyed affection being shown, such as their hand being held. Staff and the registered manager knew people well and interacted with them politely and with respect. People's bedrooms were personalised and relatives could visit people whenever they wanted and were made to feel welcome. People were involved in

their day to day care and developing their care plans where they wished to. Relatives were involved in people's care reviews. People and relatives told us staff were caring. One relative said; "It's a miracle, before (name) was so confused and anxious. (They) would call me a lot and not know why. But (name) is so much better."

People's needs were met around their communication and they were supported to take part in activities they liked within the home. Care plans included people's wishes around their end of life care where known.

There had not been any complaints. The complaints procedure was available and people and relatives told us they could complain and would be listened to. One person said, "No complaints whatsoever, the biggest tick you can find." The registered manager actively sought feedback from people and their relatives and surveys had been completed. The registered manager engaged with people and relatives. Good communication and staff involvement was promoted and staff felt supported by the registered manager and knew their roles. The staff team worked in partnership with other agencies and engaged with their local community.

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 sufficient staff available to keep people safe and meet their needs at all times.

Not all risks to people were assessed.

The provider did not always learn from incidents of falls.

Systems and processes were in place to protect people from abuse.

People's medicines were managed and used safely.

Safe recruitment practices were carried out by the provider.

People were protected by the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were not always assessed in detail before moving into the home.

The service was working within the principles of the Mental Capacity Act 2005 (MCA) and where needed, people had a DoLS authorised or they had been applied for.

Some improvements had been made to the environment for people with dementia.

People's needs were met by the homes facilities.

Staff were knowledgeable about people's needs and had the training and on-going support to do their job.

People were supported to eat and drink enough to maintain a balanced diet.

The provider worked with other health professionals to ensure people received the care they needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People could not choose when they had a bath.

People's rights to privacy and dignity were respected.

People's independence was promoted by staff.

Information held about people was secure.

Staff knew people well and interacted with them politely and with respect.

People's bedrooms were personalised.

Relatives could visit people whenever they wanted and were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care as their choices were limited.

People were supported to take part in activities they liked within the home.

People's communication needs were met.

Care plans included people's wishes around their end of life care.

The complaints procedure was available and people and relatives told us they could complain and would be listened to.

The registered manager actively sought feedback from people and their relatives.

Is the service well-led?

Requires Improvement

The service was not well led.

The registered manager did not have good oversight of the quality and safety of the home.

Accurate care records were not maintained.

Falls analysis had not considered any trends and patterns which could be identified.

Risk assessments had not always been completed in a timely manner and were not in place for all risks identified and some had conflicting information.

There were missed learning opportunities from accidents and incidents analysis and audits had failed to identify the concerns we found.

The registered manager engaged with people, relatives and staff

The staff team worked in partnership with other agencies and engaged with their local community.

Garlinge Lodge Residential 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 20 and 23 November 2018. The first day of inspection was unannounced. The inspection was undertaken by two inspectors on the first day and one on the second day.

Before our inspection we reviewed the information, we held about the home including the previous inspection report. We looked at notifications which had been submitted to inform our inspection. A notification is information about important events which the provider is required to tell us about by law. We looked at the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give us some key information about the home, what the home did well and improvements they planned to make. We took this into account when we inspected the home and made the judgements in this report.

During the inspection we met people who lived at Garlinge Lodge and observed their care within communal areas. We looked at the interactions between staff and people. We inspected the environment, including the kitchen, bathrooms and people's bedrooms. We spoke to three people, three relatives, four care staff and the registered manager. We displayed posters in the reception area inviting feedback from people, relatives and staff. We requested feedback from commissioners and health professionals and received a response from two health and social care professionals.

We reviewed six people's care records. We looked at medicines records. We reviewed three staff recruitment files, staff induction, training and supervision records and a variety of records relating to the management of

the home including staff rotas, surveys and quality audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 21 September 2017, we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to deploy sufficient numbers of staff. The provider submitted an action plan to us in response. They informed us they had a recruitment program in place, that extra staff will be on duty according to the needs of people and staff will not be allowed to work extra-long hours.

At this inspection, people and relatives told us they thought there was enough staff available to meet people's needs and ensure they are kept safe. Comments from people included, "I felt anxious living alone, I am happy here…I feel safe, I have had no falls…there is always someone about." Comments from relatives included, "I do think there are enough staff and they are good." and, "Yes there is enough staff, as soon as she stood up and the bell rang, staff came in to check her."

However, we found there continued to be insufficient staff deployed at all times to ensure people's safety whilst respecting their freedom. The registered manager had ensured staff no longer routinely worked 18-hour shifts and had made some changes to improve staffing levels since the last inspection. For example, the cook worked between eight and two o'clock and four and six o'clock and could help then if needed. The registered manager told us they continued to work six days a week until 6pm to be available if needed. However, there were still times during the day when there were only two staff available, between 6pm to 8am. The registered manager completed a dependency tool to determine people's level of needs. This showed how many staff they needed for different activities. However, it did not consider how many people may need care at any one time, the layout of the building and how people's dependency levels translated into staff hours for the home.

Out of the six care records we reviewed, three people were assessed as at high risk of falls and three were at medium risk. All six-people needed support to mobilise safely, for instance to go to the toilet or their bedroom, and to have a bath. Whilst there were risk assessments in place, the management of these meant people were restricted. For example, the registered manager told us one person chose to mostly remain in their bedroom as they felt safe there. This meant the person did not feel as safe in other areas of the home and therefore this had an impact on the person. The provider could not be assured that two staff to care for 14 people could keep people safe whilst also minimising restrictions on their freedom and choices and meeting their needs. Accident records showed that the majority of falls that happened had not been witnessed between 6pm and 8am when there were only two staff available to care for 14 people across three floors. Accident records showed that out of six falls, five of these had occurred when less staff were deployed after 5pm in the evenings or at weekends which were all unwitnessed in people's bedrooms. The layout of the building over three floors meant it was difficult to meet people's needs and monitor people's safety with two staff when people were in their bedrooms.

Staff told us there is enough staff, however one staff when asked if people are kept safe said, "Sometimes it's difficult, we try our best to keep an eye on people. There are lots of falls, sometimes it's hard to keep an eye on, sometimes in the lounge they have already fallen. Some ring and some don't ring the call bell when they

need help and by the time we get there, they have already fallen. The really vulnerable ones have an alarm on their chair." Another staff told us, "People have set bath times and most people need a staff to stay with them. Sometimes I wish we had more staff, especially around bathing times." Another staff told us, "People generally have baths weekly, some refuse. Most people have a bath day and need staff to stay with them. Some can be left like (names) for a few minutes as they are quite sensible and won't just stand up."

The registered manager told us that a lot of people mobilise independently and would move to alternative services if their needs could not be managed at the home. One person had been moved downstairs to make it easier for staff to monitor them following a return from hospital. However, this was achieved by swapping people's bedrooms and then meant the other person who was at high risk of falls, bedroom was now on the first floor. Staff told us it would be better for this person to be back downstairs.

The failure to ensure sufficient numbers of staff to ensure that staff could work in a safe way and meet people's needs at all times is a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At our last inspection we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that risks within the premises had been managed safely. An action plan was submitted by the provider who told us they would put locks in place where machinery is operated.

At this inspection there had been some improvements made and the concerns raised had been addressed. There were now locks on electrical cupboards, fire drills had been held and a risk assessment was in place for the use of bedrails. However, there were further instances where people were not kept safe from environmental risks. An empty bedroom near the communal areas and therefore easily accessible had been used to store carpet cleaning chemicals and this had been left unlocked. The registered manager rectified this immediately. There was no heating in the conservatory, which was very cold. Staff acknowledged that the conservatory was cold and moved two portable electric radiators which were stored in the corner of the conservatory and put these on. These were hot to touch and presented a potential risk of accidental scalding to one person who came and sat right next to the radiator. We therefore moved this to a safe distance to ensure their safety. We discussed this with the registered manager who agreed that these radiators do get very hot to touch, they informed us these radiators were not used in the conservatory which can't be heated and were only used to put behind people's beds for extra heat when needed and where they were not accessible. However, the risk from the use of portable radiators had not been assessed. We were told by staff that the conservatory was used by some people and we also observed it's use by people and their relatives. On the second day of our inspection these radiators had been removed from the conservatory.

The failure to ensure that risks within the premises were mitigated to ensure the safety of people is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were kept safe from other environmental risks. Fire safety risks were managed. Checks were completed for fire alarms, fire doors, fire extinguishers, emergency lighting and call bells. There was a fire evacuation plan, all people had a personal emergency evacuation plan in place and fire drills were completed. PAT testing was completed in line with the providers policy. The provider had managed the risk of legionella and monitoring checks for this had been recorded in line with their policy. Certificates indicated safety checks and servicing had been carried out as needed, for example on gas, electrics, fire extinguishers and hoists. Hot water temperatures, fridge and freezer temperatures were all monitored regularly and were

within the required range. There were risk assessments in place for some environmental risks such as food safety, stairs and pest control. A building assessment which checked for hazards and identified actions had recently been completed.

At our last inspection we identified a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that people's medicines were managed safely as medicines were left unattended. An action plan was submitted by the provider who told us that medication will be dispensed from a locked trolley.

At this inspection the provider had rectified this and medicines were administered from a locked trolley. Medicines, including 'as required' medicines, were received, stored, disposed of, and administered correctly. People had an individualised medicine administration sheet (MAR), which included a photograph of the person and their known allergies. MAR charts are a document to record when people received their medicines. There was clear guidance for staff on how to support people to take their medicines. People's medicines were securely and safely stored in a medicines trolley or a medicines cupboard and they were administered by staff who had received appropriate training and competencies.

People had risk assessments around their individual needs. However, one person with a risk history of epilepsy did not have a risk assessment or care plan to offer guidance to staff how to support the person if they were to have a seizure. The registered manager told us that they had not had any seizures since living at the home. One staff member told us that the person has had two seizures since they have lived at the home and on one occasion an ambulance was called. They described how they have noticed the person gets fidgety and anxious and told us they have noticed there is no guidance in their care file and they hadn't received any training on epilepsy. We discussed this with the registered manager who said the incident when the ambulance was called was due to the persons heart condition and that they had a 'mini stroke'. The conflicting information we received highlighted the need for clear guidance for staff. The registered manager agreed the person should have a risk assessment and support plan for this.

The provider did not always learn from incidents and accidents. There was some analysis of falls which looked at the time, location, injuries and action taken for individual incidents and improvements were made for individuals. For example, bed rails and sensor cushions were introduced for one person to help prevent further falls. However, the analysis did not always identify the root cause and therefore preventative measures. For example, that five out of six falls all occurred after 5pm at night when there were less staff and these were all in people's bedrooms and unwitnessed.

People were safeguarded from the risk of abuse. Safeguarding and whistleblowing policies were in place and worked in line with Local Authority safeguarding procedures. All staff had received training, were able to recognise the signs of abuse and could tell us what they would do in the event of a safeguarding concern.

Safe recruitment processes were carried out by the provider. The appropriate checks were made to ensure only suitable staff were employed to support people. Staff files contained all the information required such as a photo and ID. New staff were asked to complete an application form and to provide a full employment history. Interviews were held to assess their suitability and aid the decision-making process. References were sought and followed up and all staff had been subject to criminal record checks before starting work. These checks were done by the Disclosure and Barring Service (DBS) and supported employers to make safer recruitment decisions and prevent unsuitable staff being employed.

People were protected from the risk of infection and were cared for in a clean environment. Infection prevention and control policies and systems were in place. For instance, handwashing facilities and the use

of personal protective equipment. Staff were trained and understood how to prevent and control infection. We observed that staff followed procedures, for example wearing gloves and aprons.

At our last inspection we recommended the provider reviewed the procedures for cleaning equipment such as commodes. The provider informed us within their action plan they will ensure commodes are cleaned in line with infection control guidelines. At this inspection systems had been put in place to ensure these were cleaned regularly and checked daily.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 21 September 2017, we identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that premises were appropriately decorated and maintained. An action plan was submitted by the provider who told us unsuitable flooring and the hoist in the bathroom would be replaced and decorating would be done where needed.

This action had been taken and the breach of regulation had been met. The hoist in the bathroom had been replaced with a bath chair. Vinyl flooring had been replaced and all patterned carpets except one in the conservatory had been replaced. The registered manager told us that this room was not widely used and that it has never appeared to be a problem for anyone but that he would replace it if it was. There was not a plan for redecoration of the communal areas, however as people left the home, bedrooms were redecorated prior to anyone else moving in. The environment was clean.

There were pictures outside people's bedrooms to help them find their room and pictures within rooms or on doors to identify it's use, for example toilet or dining rooms signs. This helped to maintain the independence and dignity of some people with dementia. People's needs were met by the homes facilities which were accessible for everyone. A lift provided access to the upper and lower floors and bathrooms contained specialist equipment to enable people to bathe safely. The garden was only accessible from the lower ground floor. One relative told us they don't like taking their relative out due to the outside access to the building but that they were told they would be supported to do this. The registered manager told us it is accessible for wheelchairs and confirmed that he has informed the relative that staff would help with this. Where needed, people had specialised equipment, for example walking frames to support them with their mobility needs.

Assessments were person centred and included the needs of people. One person told us, "Before I moved here they asked me what I needed." However, people's needs were not always assessed in detail before moving into the home. During our inspection one person moved into the service. Their pre-admission assessment was only partially completed and there were no risk assessments and care plans in place to give staff guidance on how to support the person. The person came to Garlinge Lodge as they were having frequent falls at home and they had a specific medical condition. It was therefore essential that there was guidance in place to inform staff how to care for the person and keep them safe. There was some general guidance on the specific medical condition. We spoke to the registered manager about this who told us that all the person's care plans will be in place within one week and that he was arranging training for staff on the persons medical condition.

At our last inspection we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to follow the principles of the Mental Capacity Act 2005 (MCA). An action plan was submitted by the provider who told us they would implement capacity assessments, co-ordinate best interest meetings and complete consent to care and treatment forms.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they 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 home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. At this inspection the provider was working within the MCA and where needed, people had a DoLS authorised or they had been applied for. The provider had trained and supported staff to understand the requirements of the Mental Capacity Act in general, and the specific requirements of the DoLS. Staff could demonstrate their understanding of this. Where people had capacity, they were asked to consent to their care and care plans had been signed. Where people had a Lasting Power of Attorney (LPA) in place, this was recorded in people's care records. A LPA is a legal document that lets the person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. The provider had therefore now met this breach of regulation.

People's individual protected characteristics under the Equality Act 2010 were considered where people were happy to discuss these. This means people were protected from unfair treatment in relation to identified personal characteristics: people's age, disability, race, religion, gender, sexual orientation and gender reassignment.

Staff were knowledgeable about people's needs and most staff had worked there for many years. Relatives thought staff knew their loved ones needs well. One relative had commented, "They are used to (name) ways and how to get the best out of (name.)" Another relative said, "Since (name) came to Garlinge Lodge their needs have been carefully monitored and met." The provider ensured staff had the right induction, training and on-going support to do their job. Staff recruitment files and training records confirmed this. Inductions were structured and included orientation to the home, care planning and reporting. Staff told us they had received an induction, on-going training, competencies, supervision and annual appraisals and this was evidenced in staff files, their knowledge and their practice.

People were supported to eat and drink enough to maintain a balanced diet. People had nutrition assessments and dietary preferences in their care records. Food charts were completed, people's weight was monitored and had remained stable. Therefore, any risk of malnutrition and dehydration was managed. There was information in the kitchen regarding people's dietary needs and preferences, for example one person was on a softer diet due to their preference, rather than a risk of choking. People were offered drinks regularly and drinks were always available. Feedback on the food was positive. One person said, "I don't like red meat or strawberries and they remember that." Another person said, "The cook comes and asks me what I want and gives me a choice, I have water in my room, no complaints…I'm having chicken today and something lemon for pudding which is up my street." Comments from relatives included; "The food is very good." and "The food looked alright, I've seen (the person) a couple of times have dinner, (the person) doesn't have teeth so they cut her food up." And, "The food is fine."

We observed the lunchtime meal and saw that some people were enjoying the mealtime experience. People were sitting together, some people were talking with each other and smiling or laughing. One person who had just moved in was being made welcome. People were offered choice, for example of two main courses and if they wanted any sauces and what drink they would like with their meal. People were encouraged to

have as much as they wanted to eat and drink. People were given assistance with eating where needed and some people chose to have lunch served in their bedroom.

People were supported to live healthily and access the healthcare they needed. The provider worked with other health professionals to ensure people received the care they needed and that they were supported with various health conditions. For example, people had records of visits from GPs, district nurses and chiropodists in their care records. One person told us, "The nurse came to see me today about my ankle which I knocked. It's ok now though, any problems I will tell (the registered manager)." One relative told us, "They usually ring me to tell me the doctors coming, they wouldn't leave (the person) in pain or unwell."

Requires Improvement

Is the service caring?

Our findings

People's rights to independence were promoted by staff. For example, care plans detailed how to offer people choice with what clothes they wear and how to promotes people's independence with their personal care. Staff could tell us how they would encourage people to do certain things for themselves. However, people could not always choose when they could do some activities, such as having a bath. There was a rota for people to have a bath once a week at a time when the service could manage this safely due to the number of staff available. Therefore, risk management to ensure people's safety restricted their choices. This meant that people were not always offered choice in their day to day care as staff were not deployed to always enable this.

The failure to ensure sufficient numbers of staff to meet people's needs at all times is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 21 September 2017, we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to consistently provide care that ensured people's privacy and dignity. An action plan was submitted by the provider who told us they will ensure all staff are trained in this, are familiar with the policy, demonstrate competence and they will audit this regularly.

The provider has now met this breach of regulation. At this inspection peoples' privacy and dignity was respected by staff. Staff had received training and could tell us how they would protect people's privacy. People's care plans included how to ensure their dignity is maintained. The registered manager had completed a recent dignity in care audit. Appropriate systems were in place which ensured information held about people was secure.

The general atmosphere in the home was caring and we saw staff and people laughing together. We observed caring interactions between staff and people. Staff and the registered manager knew people well and interacted with them politely and with respect. People's birthdays were celebrated with cake and we saw a card from a relative thanking the staff for this. People and relatives told us staff were caring. Comments from relatives included; "It's a miracle, before (name) was so confused and anxious. (They) would call me a lot and not know why. But (name) is so much better." And, "They are so caring, the day staff are brilliant, if you ring up, they will always pass the phone to (the person). They always have time." And, "They are excellent when I visit, they have a good relationship with (the person). I've found it very homely, all the staff I have met are very pleasant." One care professional who visits weekly told us they always have fun with people and there is always a nice friendly atmosphere. They also commented how they never hear complaints about the food or staffing.

People's bedrooms were personalised and both people and relatives all said they were happy with their bedrooms. People's rights to a family life were respected. Relatives told us they could visit whenever they wanted and were made to feel welcome.

People were involved in their day to day care and developing their care plans where they wished to. The registered manager told us how they would sit down with people, ask them their preferences and choices and use feedback from staff to inform peoples' care plans. Relatives were also involved in people's care reviews. The registered manager told us that people were not accessing advocacy services currently as people's relatives spoke on their behalf, where needed. However, they would refer them to the relevant service if required and advocacy services had been used in the past. Advocacy services offer trained professionals who support, enable and empower people to speak up.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 21 September 2017, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that people received personalised care and had effective personalised plans in place to meet their needs. An action plan was submitted by the provider who told us that all care plans will be reviewed and updated to ensure personalisation.

At this inspection peoples care records included information about their choices, their likes and dislikes, what they need help with and what they can do for themselves. New care plans had been added since the last inspection which looked at what outcomes people want and how staff can meet people's needs. People's care plans had been reviewed regularly. The provider had therefore completed the actions they identified and this breach had been met.

However, people did not always receive personalised care as their choices were limited. For example, people did not have the choice of going out into the community. One relative told us how they would like their loved one to go out more and how they used to enjoy going to the coffee shop in the town with them. They thought this impacted on their wellbeing. One staff told us, "People only get to go out if their family take them out. We have taken them to a coffee morning but it's difficult if people are in wheelchairs or have mobility problems." There were limited activities for people outside the home, which mostly relied on relatives taking people out. We fed this back to the registered manager who told us how they had taken two people to the garden centre in their car; that three people go out with their relatives; that in the summer people sit out in the garden, and that some people have said they don't want to go out.

The provider had developed the in-house activity program to better meet people's social needs. People were supported to take part in activities they liked within the home. There were resources available such as books and puzzles. The registered manager had developed the activities on offer throughout the week and told us they were looking for a new activity for people on Fridays. Activities included church volunteers playing games with people, and external entertainers came in to do reminiscence activities, singing, and an exercise class. One person said, "Me and my friend sit together. A physio lady comes once a week. My relative (name) took me out once." One relative said "apart from Fridays, they do have someone come in." On the days of our inspection some people were using the main lounge, listening to music and other people were watching television in their rooms. The home celebrated key dates and events such as the royal wedding and Remembrance Day and there was a Christmas party planned.

The registered manager was aware of the Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Providers of health and social care services are required to follow the standard to make sure that people have every opportunity to understand and be involved in their care plans and documents on an individual basis. People's needs were met around their communication. For example, one person who was hard of hearing, kept a writing pad next to them and staff would use this to communicate with them. People's care plans included a section on communication to detail their individual needs.

The registered manager told us there had not been any complaints. People and relatives told us they didn't have any complaints. One person said, "No complaints whatsoever, the biggest tick you can find." One relative, when asked if they think they would be listened to said, "Yes, they are very approachable, you can talk to them." The complaints procedure was available and had been produced in a bigger font to be more accessible for people. The registered manager actively sought feedback from people and their relatives and surveys had been completed with positive responses. One person had said they didn't know who to speak to if they had any concerns and an action had been recorded for this person to be reassured daily on this.

At the time of our inspection no-one was thought to be on end of life care. However, care plans included people's wishes in this area where known.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 21 September 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that effective systems were in place to monitor and improve the quality and safety of the service. An action plan was submitted by the provider who told us they would implement a falls prevention and management audit tool, a dignity of care tool, a bath and shower list for people, ensure care records demonstrate people receive the care they need and regular review of care plans.

At this inspection the registered manager continued to not have good oversight of the quality and safety of the home, risks were not always clearly understood and managed, and accurate records were not always maintained. Whilst they had completed the actions they identified following the previous breach of this regulation, these were not sufficient around the risk of people falling and new concerns were identified. The providers approach to risk was more reactive than proactive. The provider had implemented a falls register analysis but this had not considered the trends and patterns which could be identified. For example, falls occurred when less staff were deployed. Where a bed rail was put in place to prevent one person falling from their bed following an incident in January 2018, the accompanying risk assessment had not been completed until March 2018. Two people with a risk history of urine infections did not have any guidance for staff to follow on how to manage the risk. Whilst these people had not had a urine infection since living at the home, guidance for staff to ensure they had enough to drink in the persons care plans could prevent this risk occurring.

Records were not always accurate and up to date to help ensure consistent support. Care records were accessible for staff but were not always legible as many handwritten records proved hard to read and therefore for staff to retrieve essential information. Some people's care records were disorganised and hard to follow, with repeated information. For example, the registered manager had added information to people care plans to make them more person centred but the previous information remained. People's care records were not always complete and kept up to date. For example, one person had a doll they liked to hold but there was no reference to this in any of their care plans. Another person liked a softer diet because they had no teeth but this reason was not recorded in their care plans. There was no mention of the bed rails in use for one person within their care plan.

Some care records held conflicting information for example, one person's risk assessment for manual handling said they needed assistance to rise from their chair, where as their falls risk assessment said they didn't have any difficulty with this. Staff confirmed they were at high risk when mobilising. A sensor mat had been put in place for this person but there was no guidance in their care plan for staff as to how this should be used effectively to support independence or falls prevention.

Internal audits were completed to check compliance, for example on infection control, care plans, health and safety, medicines and dignity in care. However, the registered manager did not always promote continuous learning by reviewing audit action plans, complaints and analysing accidents and incidents. There was missed learning opportunities from accidents and incidents analysis and audits had failed to

identify the concerns found with care records. For example, that five out of six falls that had gone unwitnessed were in people's bedrooms when less staff were deployed; and the lack of risk assessments in place for people with a risk history of urine infections.

The failure to ensure that effective systems were in place to monitor and improve the quality and safety of the service and the failure to maintain accurate and complete records is a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was a registered manager in post at the home. 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.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, deprivation of liberty safeguards (DoLS) authorisations and deaths. The registered manager was aware of their regulatory responsibilities and had notified CQC about important events such as deaths that had occurred. However, they had failed to inform CQC about some serious injuries from accidents where medical attention was sought and had not therefore met all their regulatory requirements.

The failure to notify CQC of a serious injury is a breach of Regulation 18, Care Quality Commission (Registration) Regulations 2009.

Relatives told us they thought the home was well managed. One relative told us how they had been contacted by the registered manager to inform them their relative wasn't well and said, "They are very on the ball, it's reassuring. I think (name) is really good as a manager." The registered manager had a good presence in the service and told us they looked around the home every day and chatted to people. They knew people well and promoted a caring culture.

The registered manager engaged with people and relatives through day to day conversation and meetings. Surveys held with people and relatives were analysed and showed little action needed. Where there had been comments made, the registered manager had discussed with the person and recorded these discussions. Relatives told us they were kept informed about their loved one's wellbeing where they had the right to be informed.

Staff felt supported by the registered manager and knew their roles. One staff described the registered manager as, "(Name) is quite laid back, quite easy to work for. If we've got a problem, we say. Everything is done verbally in this place. In that respect it's quite good." Staff told us they could talk to the registered manager, that they would be listened to and that they are on call at the weekends. Good communication and staff engagement was promoted. Team meetings were held twice a year and minutes were available. The staff team worked in partnership with other agencies and engaged with their local community. For example, the local church provided volunteers on a Monday.

The registered manager told us how they kept up to date with best practice as a member of the Royal College of Nursing, through reading care magazines and receiving CQC newsletters.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that risks within the premises were mitigated to ensure the safety of people.

The enforcement action we took:

Warning notice to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured that effective systems were in operation to monitor and improve the quality and safety of the service and failed to maintain accurate and complete records.

The enforcement action we took:

Warning notice to be issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured that there were sufficient numbers of staff to ensure that staff could work in a safe way and meet people's needs at all times.

The enforcement action we took:

Warning notice to be issued.