Carlton Hall (Lowestoft) Limited

Carlton Hall Residential Home

Inspection report

Chapel Road
Carlton Colville
Lowestoft
Suffolk
NR33 8AT

Tel: 01502513208
Website: www.carltonhall.co.uk

Date of inspection visit:
20 March 2018
27 March 2018

Date of publication:
14 June 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Carlton Hall Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. This service does not provide nursing care. Carlton Hall Residential Home accommodates up to 60 older people in one adapted building. There were three units in the service, one in the main part of the building, another was a newer extension called The Granary, and a unit specifically for people living with dementia, although people living with dementia also lived in the main and Granary units. The service is also registered to provide personal care in a domiciliary care agency to people living in their own homes in the purpose built bungalows on site. We also inspected the personal care service.

This was an unannounced comprehensive inspection. During this inspection of 20 and 27 March 2018 there were 53 people living in the residential home, some were living with dementia, and there were 15 people using the domiciliary care service.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager told us that they would be stepping down from the role of registered manager and was undertaking the head of care position. The application to cancel their registration had not yet been sent to us. There was a manager in place for the residential care home and a manager for the domiciliary care service. The manager for the care home told us that they would be making an application with us to be the registered manager.

At our last comprehensive inspection of 30 November 2016 this service was rated overall as Requires Improvement. We identified a breach of Regulations in relation to the standard of the care plans, staffing and the quality assurance processes. We issued a warning notice in respect of the concerns about staffing. The provider wrote to us and told us the improvements they intended to make. We carried out a focussed inspection in March 2017 to check on the staffing situation and found that the provider had made the necessary improvements.

You can read the reports from our last inspections, by selecting the 'all reports' link for Carlton Hall Residential Home on our website at www.cqc.org.uk.

An incident had happened in the service which is subject to an investigation and as a result this inspection we did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk to people relating to avoidable harm. This inspection examined those risks.

During this inspection of 19 and 27 March 2018 we checked that the provider had made improvements

following our comprehensive inspection of 30 November 2016. We also checked that the improvements identified in our focussed inspection of 9 March 2017 had been sustained. We found that the service had maintained staffing levels in the service to meet people's needs. However, we found shortfalls in the service and improvements had not been made in relation to the governance systems and the way that people's care was assessed, planned for and met. We also identified that there were continued breaches of regulations relating to the provision of personalised care and the governance of the home.

The provider and the management team had failed to make adequate improvements in the service to provide people with safe and good quality care at all times. The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

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

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The service did not have robust systems to identify when people were at risk of avoidable harm. Because of this the processes in place did not support the provider and management team to address the risks and develop systems to reduce them. This meant that people were at potential risk of harm. There were systems in place to ensure people were provided with enough to eat and drink. However, where people were at risk of choking, the service did not have processes to adequately identify and act on risk.

The systems for monitoring the service were not robust enough to independently identify shortfalls and to support the provider and management team to continually improve the service people received. The service had missed the opportunity to use the learning from our previous inspection and an incident to improve the service.

The service had accepted the support from the local authority to improve their care plans. However, people's care plans did not provide guidance for staff on how people's needs were to be met. This included people's conditions and how these affected their daily life. The records maintained by staff to identify how people's needs were met were not detailed enough to show that people were provided with the care they needed to meet their assessed needs. This included the records kept to evidence that people were receiving good end of life care. We found that the care plans for the people who used the domiciliary care service provided guidance to care workers to meet people's needs.

People had access to health professionals, where required. However, the service had not always followed up referrals when people were at risk of harm. Staff worked with other professionals involved in people's care.

Improvements were needed in the safe management of medicines. There were shortfalls in the recording to show that people had received their medicines as prescribed. Records identified that people were not always provided with their prescribed creams. In addition the guidance for staff relating to the creams were not always clear.

There were infection control processes and procedures in place which reduced the risks of cross infection. However, we identified some areas needing improvement to reduce the risks to people.

Improvements were needed in the environment. This included signage to support people to navigate around the service. We also identified some areas of risk in the environment. Once these were pointed out they were addressed immediately.

People were supported by staff who were trained and supported. Staff supported people in the least restrictive way possible; the policies and systems in the service supported this practice.

People were treated with respect and compassion by the staff working in the service. People had positive relationships with the staff who supported them. However, due to the shortfalls identified during our inspection we were not assured that people were provided with a caring service at all times.

People were provided with the opportunity to participate in activities that interested them. However, we saw that there were times, outside of the planned activities, that people were disengaged. Staff listened to what people said and acted on their wishes.

There was a complaints procedure in place and people understood how to raise concerns.

Staffing levels in the service were organised to provide people with assistance when they needed it. Recruitment of staff was done safely and checks were undertaken on staff to ensure they were fit to care for the people using the service.

You can see the actions we have asked the provider to take in 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?

Inadequate

The service was not safe.

People were not protected by the systems to assess and reduce the risks of avoidable harm.

Improvements were needed in the infection control processes.

Staffing systems meant that staff were available when people needed them. The systems for the safe recruitment of staff were robust.

The systems in place to manage medicines safely and ensure people received their medicines as prescribed were not robust.

Staff had been trained in how to keep people safe from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were needed in the systems to assess and monitor if people were eating and drinking enough.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support. However, guidance from health professionals were not always followed up and recorded in people's care plans.

Improvements were needed in the environment to provide an accessible home for people, including those living with dementia.

Staff were trained and supported to meet the needs of the people who used the service.

The service was working within the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not provided with a caring service at all times. This was because we found shortfalls in the service provision. However, we saw that the staff interacted with people in a caring and compassionate way. People were treated with respect and their independence was promoted and respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed in how people's wellbeing and needs were assessed and planned for to ensure their individual needs were being met. Improvements were needed in the systems in place to support people at the end of their life.

People were provided with the opportunity to participate in activities. However, we saw some people were not engaged outside of the planned activities.

There was a system in place to manage people's complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Improvements were needed in the ways that the service monitored the service to ensure that people were provided with good quality care at all times.

The service had failed to make improvements overall in the care provided to people. In addition the quality assurance systems were not robust enough to independently identify shortfalls and address them.

The service provided an open culture. People were now asked for their views about the service.

Carlton Hall 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced comprehensive inspection took place on 20 and 27 March 2018 and was undertaken by two inspectors. On the first day of our inspection there were also two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with 19 people who used the residential care home service and two relatives. We observed the interaction between people who used the service and the staff. We also, with their permission, visited three people who used the domiciliary care service in their own homes.

We looked at records in relation to seven people's care in the residential care home and of three people in the domiciliary care service. We spoke with the registered manager, the acting manager of the residential care home, the manager of the domiciliary care service, the managing director, the human resource director, and the care director. We also spoke with eight members of staff including administration, senior care, care, domestic, catering, activities and maintenance staff in the residential care home. We spoke with one care worker in the domiciliary care service. We looked at records relating to the management of the service, three staff recruitment files, training, and systems for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection of 30 November 2016, Safe was rated Requires Improvement. We served a warning notice following the inspection in relation to a breach Regulation 18: Staffing of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

This was because we were concerned that the arrangements for staffing in the residential care home were not sufficient to meet people's needs safely. We told the provider about the issues we had found and gave a date of when they must make improvements. We undertook a focussed inspection on 9 March 2017 to check that the provider had addressed the shortfalls we had identified in our warning notice. We found that the provider had met the requirement of Regulation 18: Staffing of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. There was no change to the rating of the service following that inspection. During this inspection in March 2018, we found that the improvements made in the staffing in the service had been sustained. We found shortfalls relating to how the service assessed and managed risks to people, and medicines management. Safe was now rated as Inadequate.

On our arrival to the service on the first day of our inspection we were let into the residential service by contractors, who were undertaking work in the environment. We were passed by two staff who did not ask who we were and why we were in the service. We asked a third staff member where we could find any members of the management team, we were then shown to an office where the registered manager was. We told the registered manager how we accessed the service, they said that they had spoken with the contractors about not letting people in. Improvements were needed to ensure the security of the home.

The systems in place to assess and reduce the risks to people were not robust. Care records included risk assessments which asked the staff member completing them a series of questions about the person. The answers were graded then totalled giving the level of risk, for example with moving and handling. However, there was no follow up information in place to guide staff about how these risks were minimised. For example, one person had been assessed at risk of developing pressure ulcers. Their care plan gave conflicting guidance when the person should reposition. The care plan said that staff should check the person's skin daily and report any concerns to senior staff and the community nurse. There was no further information to say what they should be looking for and which parts of the person's body were particularly vulnerable to developing pressure ulcers. Their care plan stated that they had a pressure ulcer on their bottom, but there was no detail of if this was graded. The record of professional visits identified that the district nurse had visited in March 2018, the pressure ulcer had healed but this was not in the person's care plan.

One person's care plan stated that they had a pressure ulcer on their heel and identified the equipment they used to relieve this. However, there was no information about what setting the airflow mattress should be set at or if this was checked. There was no further information to guide staff on the support they required to maintain skin integrity. There were charts in place to show that the person was assisted to move position, but there was no information on the charts or in the care plan about how often they should be supported to reposition. Another person's records identified that they needed support to reposition every two to four

hours, the charts in place did not show that this was done as directed. We were concerned that the systems in place did not adequately guide staff to how the risks of people developing pressure ulcers or pressure ulcers deteriorating.

There was poor information relating to people who were at risk of choking. Two people's records we reviewed said that they may not swallow their food and drink and keep it in their mouth. There was no guidance for staff about what they should do if this happened to reduce the risk of them choking. One of these records stated that the person did this on a 'bad day', there was no information about what a bad day was for this person. One of the person's records showed that they had been referred to the speech and language team (SALT) and the type of softer food they were to be provided with.

We reviewed another person's records. Their risk assessment for choking showed there was no risk. However, we saw in the records that contact was made with professionals about the person and that the staff had a discussion with the SALT team in January 2018. This was following the person coughing when they ate first thing in the morning, which could be an indicator that they had problems swallowing. The records identified that the SALT team did not visit because it was not necessary. We looked at the daily records and incident forms for January 2018 and could find no records of a choking incident. However, in February 2018 the daily records identified that a staff member had seen the person whose face was a different colour to their usual appearance and they were struggling to breathe. The staff member slapped their back and dislodged a piece of chicken. The person's face then regained usual colouring. There was no incident report about this and the risk assessment and care plan had not been updated following this incident.

We looked at the daily records previous to the SALT discussion. We also found that in December 2017 an entry in the daily records was, "Choked on some chicken, so have got [person] some soup." Again there was no incident report. We fed this back to the provider, and the registered manager on the first day of our inspection. We were concerned because there were two potentially serious incidents that had not been appropriately followed up. When we returned for our second visit the acting manager told us that they could only find one incident of choking since January 2018, despite us being able to find two, one being prior to this month. There had been no detailed checks undertaken to check how many choking incidents this person had. The manager said that they had contacted the SALT team and a visit was planned. We checked this person's records and there was a handwritten addition to the care plan telling staff to cut up the person's food and observe them when eating. The risk assessment had been reviewed to now show that the person was at low risk. The questions on this form had incorrectly been answered which resulted in the low risk rating. This could result in the person receiving inappropriate and unsafe care and support.

Another person's care plan stated that the person was under the SALT team due to swallowing difficulties. Their malnutrition universal screening tool (MUST) assessment said that the person had a history of aspiration. There was no other information in this assessment or care plan about how the staff should support the person to reduce the risks of them choking. There was a hospital transfer letter in their care records which stated that the person was on a 'pureed diet', but there was no information in the care plan about this.

A further two people's records we reviewed identified that they were at risk of choking. But there was no guidance for staff on how these risks were reduced.

Records did include guidance for staff about how to prepare thickener for people's fluids for two people whose records we reviewed but this guidance was not in place for another two people.

There was a sweet trolley in the library and some people told us that they were going to help themselves to some sweets. One person said, "It is good, I can have one when I want." However, we had found that for people who were at risk of choking, there was no risk assessment in their care records about if they took a sweet and choked on it. Staff told us that the people who were at risk of choking were not mobile. However, one of the people whose records we reviewed walked with the use of a walking frame and we saw them walking around the home alone.

Where people were at risk of falls, the care plans did not give clear guidance to staff about how falls were to be minimised. The falls register did not include analysis, and identification of possible trends. After each recorded incident the manager had completed a review. However, these did not state what action had been taken and if there had been an investigation and/or analysis. Records showed that two falls had been due to urine on bathroom floors but there was no evidence to show that the service had looked into this and whether the person needed any further support. Another person's records stated that on two occasions the person's legs had given way when they were supported to use the toilet. There were no records in place to show if they were able to weight bear.

On the first day of our inspection we identified that a window, which was waist level on a stair case in the Granary did not include a window restrictor. This was a problem because people could climb out of the window and fall. On the second day this had been addressed. However, we found some window restrictors had the keys left in the locks.

In the dementia unit, on the first day, there was a pot of food and fluid thickener left on the work top in the communal area. This was a risk because it could have been accidently accessed by a person using the service. If it was eaten there was a risk that it could have swollen and cause the person to choke. The prescription label on the pot stated that this should be kept securely. On the second day, the pots had been placed in secure cupboards.

The systems in place to monitor the safety of the service were not robust. For example, we saw that the ceiling in a toilet was cracked and there was a loose fan cover hanging down. On another toilet there was an exposed pipe which was hot to touch. When we pointed these out, actions were taken immediately to address them. There were no risk assessments in place for people who chose to use the stairs rather than the lift.

There was a system in place to reduce the risks of legionella bacteria in the water. Water temperatures were also undertaken to reduce the risks of people scalding themselves. However, on the first day of our inspection we found that we could not hold our hands under the water in a sink because it was too hot. On the second day we were told this had been addressed. We found the same in another toilet on the second day. Once we reported this the valve to regulate the water temperature was replaced. We were told that a check on all of the hot water taps was done on 21 March 2018 and all of the valves had been working properly.

On the first day of our inspection visit we found that one person's medicines were in the monitored dosage system when they should have been administered as prescribed. A staff member told us this was when the person when out with their relative. There had been no planning around supporting the person with their medicines when they were away from the home or guidance sought from health professionals about if this could be taken at a different time. In addition there was no recording on the Medicine Administration Record (MAR) to show why the person had not received their medicines. On the second day we were told by the manager that this was being addressed. We also found a discrepancy on one of the medicines, which did not tally with the number that should be left identified in the records.

Some people were prescribed medicines to be taken as required (PRN). We found that one person was prescribed medicines to assist them with their mental wellbeing. There was no detailed protocol in place to identify how the person could be supported before the medicines should be considered for administration.

Guidance from health professionals was being sought in relation to people's medicines. However, we were not assured that this was always effective or recorded appropriately. For example, one person's records identified that the nurse practitioner had stopped their medicines because they had difficulty swallowing in September 2017. However, in December 2017 the GP prescribed liquid medicines for anaemia, the records stated that sometimes the person would be unable to take this. There was no information about if this would affect the person or the signs and indicators of the condition becoming worse. There was no further information about if the medicines that had been stopped could be supplied in liquid form and if the lack of their medicines would affect them.

Two people's MAR had been signed to state that the person had received medicines, however, we found that these did not tally with the medicines in stock, because there were more medicines than there should be.

We reviewed records of the administration of topical medicines. These were not appropriately completed to show that people had received these medicines as prescribed. In addition the guidance provided on the MAR was not always clear and the care plans were not clear. For example, one person's care plan stated that they could get sore areas and had cream for this. There was no information what part of the body that could be sore, how staff could identify this, what cream should be applied and how often. The acting manager told us that a pharmacy professional had provided training to staff in December 2017 about the importance of people receiving their topical medicines, such as creams, as prescribed. Despite this, there were still shortfalls.

All of the above is a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were satisfied with the arrangements for their medicines administration. One person said, "Yes they [staff] bring them round, no problem at all. I manage to take them myself, they [staff] make sure you take them, in front of them." Another person commented, "My tablets, they are mostly on time and correct." People's choices were listened to an acted upon relating to their medicines for pain relief. One person said, "I signed to say I would do the paracetamol myself. My doctor prescribed eight, but sometimes I only want four a day." One person who used the domiciliary care service told us about their medicines, "I get help with my medication now, it's just easier isn't it? I don't have to worry and they might as well while they [staff] are here."

Records showed that staff who were responsible for administering medicines had received training. We observed staff giving people their medicines, they did this safely and checked the medicines administration records (MAR) before providing people with their medicines and signed them when they had seen people taking them.

The MAR and care plans for people using the domiciliary care service were appropriately completed and identified the support people required with their medicines.

Despite the shortfalls, we had identified during our inspection people told us that they felt safe living in the service. One person said, "I love it, because they [staff] are always there, say if you didn't feel well, they've always got someone to look after you. I've never been hurt, you can walk outside. I wouldn't want to be anywhere else." Another person commented that they felt safe because, "They [staff] are here all the time,

you're not left on your own." Another person said, "I feel safe here knowing there's somebody there." Another person commented, "They are very kind and very caring, they make me feel safe here." One person's relative told us, "Family member] was trying to get out of their chair and their leg gave way. They [staff] were there, they told us when we came in [family member] nearly had a fall this morning, but they didn't hurt themselves at all. They [staff] are not just sitting there in the chair and ignoring them [people using the service]." One person who used the domiciliary care service said, "I feel very safe knowing someone is coming to see me and they always lock up (doors) afterwards and make sure all the windows are closed if I want."

We reviewed the care records of three people who used the domiciliary care service. One of these people had swallowing difficulties and was prescribed with thickener for their fluids, which they refused to have. There was a clear plan in place for this and staff we spoke with were aware of the person's preferences.

Staff had received safeguarding training and understood their responsibilities in keeping people safe from abuse. Where a safeguarding concern or incident had happened, the service had taken action to reduce the risks of future incidents.

An incident had happened in April 2017 relating to the unsafe use of bed rails. The registered manager told us how improvements had been made to learn from this. Actions taken included observations on the person, their bed rail assessment was updated and the staff member involved was retrained and discussions were held in supervision. This identified that action had been taken following this incident to protect the person and others.

Equipment, including hoists and fire safety equipment, had been serviced and checked so they were fit for purpose and safe to use. Portable electrical equipment had been checked to ensure they were safe to use. There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire. Fire safety checks were undertaken and there were fire drills completed to ensure that staff were aware of how the service should be evacuated, if required. There was a business continuity plan in place which identified the actions that staff should take in an emergency, such as a gas leak, fire or flood.

People told us that they felt that the service was clean and hygienic. One person said, "Every day [bedroom is cleaned], I'm happy with it, they're quite good." Another person commented, "Lovely, every day they [staff] are in to clean my room. Yes it does [meet person's standards]."

We saw that in one toilet there were open yellow bags containing used aprons and gloves creating an infection control risk. Also present in the corridor were open white bags containing clear bags with people's clothing which were also open. The registered manager told us that these were going to be transported to the laundry.

We saw staff collecting disposable gloves and aprons these when preparing to support people with their person care to reduce the risks of cross infection. Staff had received training in infection control and food hygiene. The service had achieved the highest rating in a food hygiene inspection. Toilets and bathrooms held hand wash gel and paper towels, in addition there was hand sanitiser in the entrance of the service. Hand washing guidance was seen in the staff bathroom. The service had a resident of the day system which included checks of mattresses, and deep cleaning bedrooms.

The acting manager told us that they had invited infection control professionals to the service three weeks prior to our inspection. They had taken advice and acted on them, this included providing enclosed toilet roll holders.

People told us that they felt that there were enough staff in the service to support them. One person said, "The carers are always there, constantly walking around, they're always pleased to help." Another person commented, "There's always someone [staff] here [main lounge]." People also told us that if they needed assistance, such as when they used the call bell, staff provided this promptly. One person said, "Mostly they [staff] respond straight away." Another person commented, "I don't need to [use the call bell], they [staff] are always there." Another person told us, "You pull your cord, and within five minutes they're here. I've got one here [call bell cord by their chair], one by the bed and one in the bathroom." Another person said, "The staff are always here, even during the night if you call them. Sometimes it would be immediately and sometimes a few minutes." However, one person commented, "I sometimes need the toilet but the staff take too long to come and I don't always make it there on time. I find this embarrassing." The people who used the domiciliary care service told us that there were never any missed visits and the care staff always turned up for their planned visits.

Staffing levels in the service were appropriate to meet people's needs. We saw that staff were available when people needed assistance. There was a system in place to calculate the numbers of staff to meet the needs of people. The registered manager told us how the service was staffed each day, which was confirmed in the records we saw. The registered manager told us that the service were recruiting for unit leaders. They used agency staff, which the registered manager told us for approximately six shifts each week. The registered manager said that the service used the same agency staff to ensure consistency. We had received concerns about the staffing levels in October and November 2017. We had written to the acting manager, who sent us evidence of how the service was staffed to meet people's needs.

Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection of 30 November 2016, Effective was rated Requires Improvement. We recommended that the service explored guidance relating supporting staff to care for people living with dementia and how the environment was designed and decorated to support people living with dementia. In addition improvements were needed in how the service assessed people's capacity and in people's mealtime experience. At this inspection we found that staff had been provided with training in supporting people with behaviours that may challenge others. Improvements had been made in people's dining experience. However, improvements were needed in how the service assessed and reduced risks to people relating to eating. We found that there were still shortfalls in the environment, for example signage to support people to navigate around the service. Improvements were needed to follow up guidance received and referrals made to health professionals. Effective remained rated as Requires Improvement.

People's records did not sufficiently guide staff on how to reduce risks for people who had specific dietary requirements, including choking and diabetes. Two people's records we reviewed identified that they had diabetes and required a 'diabetic diet'. There was no further information about the warning signs that they should be aware of relating to diabetes and actions staff should take.

One person's records identified that they had lost 10 kilograms in a month. Their malnutrition screening tool assessment still stated that they should be weighed monthly and there was no evidence to show that a referral had been made to health professionals such as a dietician. In addition there was no care plan or risk assessment in place relating to how to reduce the risks of malnutrition. We were told following our inspection that there had been an error in the recording of the weight loss. The person had been re-weighed and had not lost this amount of weight, but this had not been included in the records.

Another person's care records stated that they could not be weighed. There was no further information show that the service had considered alternative methods of checking if a person was losing weight. Their care plan did state that they received a high calorie diet and that they were to be provided with snacks, but there was no information what snacks or how often they were to be provided. Another person's MUST records stated that they had lost four kilograms since September 2017. The document stated that the person should be encouraged to have snacks and drinks. There was no reference to what and how often and this was not in their care plan. One person told us that they could have snacks, "Yes, we're offered cake, biscuits."

People were provided with choices of hot and cold drinks throughout our inspection. However, people's care records did not identify the individual recommended amount of fluid they should have each day. This included for people whose records stated they were at risk of developing urinary tract infections (UTI) and chronic kidney disease. In addition fluid charts which identified what people had to drink that were reviewed had no recordings after 6pm until the next morning. They were not being totalled at the end of the day. Therefore the system in place to monitor what people had to drink were not robust enough to identify if people had enough to drink.

All of the above is a breach of Regulation 14: Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were provided with a choice of food and they liked the food they were provided with. One person said, "I have breakfast in my room, the food is all lovely. It suits me, you have quite a choice, they say to you is there anything else you would like? They bring sauces, salt and pepper, they're all there. You can have tea or coffee, cranberry and orange drink." Another person commented, "I look forward to my meals, I like the food." Another told us, "The food is excellent, you can't fault it and I like my food. It's always nicely laid out and that's what I like." Another person said, "If you didn't fancy anything they'd offer you other things." One relative commented, "The food looks nice here, there seems a good variety." One person who used the domiciliary care service said, "The food is good, they [staff] make me my meals."

People told us that they had regular choices of drinks. One person said, "They always bring me a mug of tea, because I can handle a mug better. They bring a tea pot so that I can have a second cup. In the evening they normally come round about 7.30pm, I have a cup of tea. You can have whatever you like." Another person commented, "We get a good choice. I have to drink water."

We saw that people were asked for their choices of meals for the following day. The chef told us that this was to enable them to ensure there were enough types of dishes and to limit waste. However, they added that if people made another choice on the day, this was respected. Another staff member said that they wrote 'undecided' if people said they would choose later. One person told us about their meals choice, "I can't remember what I ordered." Another person said "It's always a surprise for me."

We saw that people's choices were respected in what they wanted to eat for and where in the service they chose to have their meals. People were encouraged to eat independently and staff promoted independence where possible. A positive dining experience was created. The mealtime experience was pleasant and staff were available to assist people who needed help. Staff also made certain that people were satisfied they had eaten enough before taking their plates away.

We spoke with the chef who told us they had attended a course to learn about the different consistencies of diets to be provided to people who had difficulties swallowing or were at risk of choking. They told us how they provided softer diets in an attractive way to make them appealing to people. They showed us a meal prepared for a person who had a softer diet and it was presented in an attractive way. The chef said that they observed what people ate and spoke with them about their likes and dislikes. If people did not want what was on the menu they could make alternative choices.

Discussions with the acting manager and records showed that the service worked with other professionals involved in people's care to ensure they received a consistent and effective service. Records showed that where there had been concerns about a person's health, they were referred to health professionals and any advice was recorded. However, this sometimes conflicted with the care plans and they had not been updated to reduce the risks of confusion. One person's records showed that on 11 March 2018 a body map was completed and an entry in the daily records identified that the person had a blister on their elbow, that staff were to keep an eye on it and if it popped to contact the community nurse. There was no other information in this person's records about if this had been checked and what the current status was. There was also information in the professional visits records where the community nurse had been treating a person's legs, they had left dressings in the service in March 2018 in case there was leakage. There was no information elsewhere in the records about the treatment of the person's legs.

People told us that they felt that their health needs were met and they were supported to see health

professionals if needed. One person said, "I have had the chiropodist." Another person commented, "I have my own doctor, they kept me on, the last time [they were ill] they [staff] said I think we'll get the doctor in to see what he thinks." Another person said, "I see the GP that comes to the care home."

Where people moved between services, for example if they required hospital admission, the newly developed care plans we reviewed included a yellow folder which held important information about the person which would be transferred to hospital with them, including if they wished to be resuscitated.

There were systems in place to ensure that staff were provided with training and support and the opportunity to achieve qualifications relevant to their role. Staff told us that they were provided with the training that they needed to do their job. This included training in safeguarding, medicines, moving and handling, fire safety, and dementia. There were notices in the staff office advising of training that was booked in March 2017, including Control of Substances Hazardous to Health (COSHH), skin tears and fire safety.

New staff were provided with an induction course, which included training and shadowing more experienced staff. Where new staff had not completed a recognised qualification in health and social care, new staff were supported to complete the Care Certificate. This is a recognised set of standards that staff should be working to. Staff told us that they were supported to undertake qualifications relevant to their role.

Staff told us that they were supported in their role. Records showed that staff were provided with one to one supervision meetings. These provided staff with a forum to discuss the ways that they worked, receive feedback on their work practice and used to identify ways to improve the service provided to people, including identifying any training needs they had. The manager told us as well as the one to one supervisions, staff also received group supervisions and observed practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The acting manager understood when applications should be made and the requirements relating to MCA and DoLS. Staff had received training in the MCA and DoLS. We saw that staff sought people's consent before they provided any support or care, such as if they needed assistance with their meals and where they wanted to spend their time in the service. Care records included information about if people had capacity to make decisions and documents had been signed by people to consent to their care identified in their care plan. The records included best interest DoLS assessments, which stated if people required to have DoLS in place and any best interest decisions.

People told us that the staff sought their consent before they provided any care or support. One person said, "They [staff] said would you like us to do it for you [assist with their medicines], so I said yes let's try it."

Another person told us that they felt that their freedom was not restricted, "You can do what you like, go around the home, sit and yarn, walk the long way round, I enjoy seeing people."

Since our last inspection changes had been made to the environment, this included a covered walkway to give inside access between The Granary and main units. There was further refurbishment being undertaken. In the grounds a coffee shop was being built. The registered manager also told us that new bungalows were being built on site and there were plans to extend the residential home further from April 2018. We saw that there were risk assessments in place relating to the building works. We saw that there were contractors in the service. One person said, "There is work going on and loads of new faces keep coming and going I sometimes wonder who they are," Another person commented, "The views from the windows are nice here when the vans are not parked in the way." Another told us, "I'm really surprised, they've not interrupted me at all, they've done a lot, decorating again now." One person's relative said that they had not been formally informed about the building work, "I have heard about the building work and decoration work going on but this has been by word of mouth." However, notices were in place advising of the work being undertaken.

Records showed that safety checks were undertaken as required, including electrical and gas safety although we identified other areas in need of improvement, for example, the hot water temperatures. People's bedrooms included items of their personal memorabilia which reflected their choices and individuality. The environment had communal areas that people could use, including lounges and dining areas. There were areas in the service where people could see their visitors in private.

There was equipment available to assist with people's mobility including passenger lifts and hoists. In the dementia unit, people's bedroom doors were painted in different colours to resemble usual front doors. There were some personalise laminated signs. However, in the other units there were no other things in place to support people to recognise their bedrooms, such as signage, pictures or memory boxes. The corridors all were similar with little to distinguish one from another. The walls and floor colours were indistinct and therefore potentially confusing.

There were enclosed garden areas with raised beds. In addition at the front of the service there were grounds with ducks and horses that people could see. One person said, "They [staff] take you out in a wheelchair, all around the gardens. You really couldn't wish for a better home." We overheard a member of staff talking with a person about going out for a walk in the grounds. Another member of staff was reminding a person of how they had named the ducks on a previous occasion. Another person told us, "I've got a nice view of the garden, a door to get out there in the garden, my [relative] helps with the garden outside my window, bought me some plants to put in the space."

Requires Improvement

Is the service caring?

Our findings

At our last comprehensive inspection of 30 November 2016, Caring was rated Good. Whilst we found that people were treated with respect and kindness by the staff working in the service, because of the shortfalls we found overall during this inspection, people were not provided with a caring service at all times. Therefore Caring was rated as Requires Improvement.

CCTV had been installed in the communal areas in the service. The registered manager said this was around October/November 2017. This was to enable to management team to review if something happened. We discussed this at feedback of the first day of our inspection. We were told that because of the size and layout of the building it was installed for security. We were told that the service had consulted our guidance, developed a policy and had received consent. We saw the CCTV policy which stated the purpose of this and who had access to the data and consent forms had been rolled out to staff. People's care plans had been signed to consent to photography but there was no information relating to the use of CCTV. We were told that signs had been put up in the service advising people of the use of the cameras. The provider needs to ensure that the appropriate consent for the use of CCTV has been obtained from the people living in the home, this includes ensuring processes are in place to carry out best interest decisions for those people who may lack capacity to make this decision.

People spoken with said that the staff were caring and treated them with respect. One person said, "The night staff are so good, I don't sleep very well, and this morning 2am, I pulled my bell and said can you bring me a cup of tea please. They have enough time for me, anytime of the day." Another person said that when they were ill, "They were bringing me hot lemon when I had a chesty cough, without asking." Another person said, "The staff here have always got time for you, they are very friendly." Another person commented, "They're lovely, very, very good they are. I can honestly say that there's not one helper I don't like." One person's relative told us, "The staff all love [family member], they're just really, really friendly."

One person who used the domiciliary care service said, "The carers are nice to me and kind." Another commented, "Staff are very kind." One person said that the staff showed, "Great respect," for their home, which they appreciated.

There was a relaxed and friendly atmosphere in the service and people and staff clearly shared positive relationships. Staff talked about and with people in a caring and respectful way. We saw examples of caring and compassionate care. We saw a staff member speaking with a person who was reluctant to eat, they encouraged the person and showed care and empathy. They held the person's hand and spoke quietly with them. Staff spoke with people in a caring and calm manner. They positioned themselves at people's eye level when speaking with them and gave them time to share their views.

We saw that staff knocked on bedroom and bathroom doors before entering. When people wanted to discuss their personal care needs, staff responded quietly in a way which respected their privacy and dignity because they could not be overheard by others. One person said, "They always knock [on doors before entering], yes they are good."

People told us how their independence was promoted and respected. One person said, "They [staff] come in and see if I'm managing, I dress myself." Another person commented, "I try and do things for myself, but if I can't they [staff] are here. I can walk down for my food and back…Getting up off the [dining] chair is very hard, and they assist me to get up." Another person told us, "I ask them to put the toothpaste on my brush for me." Another said, "I get myself part washed and they [staff] come and do my back for me." However, another person commented, "I would like to do more physical activity to make myself more independent but it never happens." We saw staff supporting a person to eat and encouraging their independence.

People's views, and those of their representatives where appropriate, were listened to and their views were taken into account when their care was planned and reviewed. This included their choices and usual routines, such as their choices of the gender of staff who supported them with personal care and their preferred form of address. One person said, "They say would you like a bath tonight, more often than not I go. I don't like a shower, always a bath." Another person told us, "A male carer responded to my call [bell] and I said could I have someone to help undress me, and he said would you like me to get a female carer?" One person's relative said, "[Named staff member] went through family member's] family history with us, they've gone through everything, they asked me about their needs." Another relative told us, "The care plan was completed when my [family member] arrived, we reviewed it a few weeks ago and have made minor changes."

One person commented, "I have my care book in my room, but no one has explained to me what is in it." Another person said, "When I arrived at the care home they asked me a lot of questions about my likes and dislikes, but you always get the same."

We reviewed three care plans of people who used the domiciliary care service. They detailed people's preferences including their preferred care staff and the times of their visits. Discussions with one person and a staff member identified that the staff knew the person well and their preferences. One person told us that their and their partner's preferences were respected, "[Partner] doesn't like to get up as early as me so they [staff] will come back later for [them]."

People told us that they could have visitors when they wanted them. Records included information about the relationships that people maintained which were important to them. The records identified where people had received visitors. One person told us, "My own hairdresser comes in." Another person said, "They [staff] always make my visitors welcome, tea and coffee."

Requires Improvement

Is the service responsive?

Our findings

At our last comprehensive inspection of 30 November 2016, Responsive was rated Requires Improvement. We found a breach Regulation 9: Person centred care of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. This was because improvements were needed in how people's care needs were assessed, planned for and met. The provider wrote to us to tell us about the improvements they planned to make. However, at this inspection we found that there were still shortfalls and there was a continued breach of Regulation 9: Person centred care of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Responsive remained rated as Requires Improvement.

The registered manager told us that the local authority had offered help with improving their care plans. The acting manager told us that they had held group supervisions with staff to provide guidance on the care planning records. We saw the minutes of staff meetings in January and March 2018 where the care planning records were discussed, this included in January where it was stated that care charts had been signed as completed but they had not. Discussions with the acting manager and the registered manager identified that they did not have a good working knowledge of how to improve the care plans. The acting manager told us that it was senior staff's responsibility to complete the documents. We spent some time with them at the end of the inspection discussing how improvements could be made. It was not clear why, in over a year these improvements had not been made to improve the service provided.

People's care plans and risk assessments were kept in individual folders, each had a photograph of the person on the front and a list of their conditions. However, these conditions were not always explained in their care plans, including the signs and indicators of their condition, when they may be unwell and any actions that staff should take. For example two people's folders stated that they had 'CKD Stage 3' in the care records there was no information what this abbreviation or the stage meant (Chronic Kidney Disease). In addition there was no information about how this condition affected their daily living and, for example, if they required to have a certain amount of fluids each day.

There was limited information in care plans, if people were living with dementia and how this affected them in their daily life. One person's records stated that they were living with Lewy Body Dementia, there was no explanation of what this was and how it affected the person other than that it was 'progressing' and that their 'memory was not so good.' Therefore there was a risk that staff would not know how best to support this person.

Another person's folder stated that they were living with three mental health conditions, there was only a mention of one of these conditions in their care plans. For this it had been recorded that this was triggered by not eating or drinking properly. They were supported by the mental health team and in 'extreme cases' they were to be contacted. No information about what an 'extreme case' would look like for this person. There was no further information about the other conditions that the person may have required support with, how these affected their wellbeing and how staff were to support them. The records talked about bad days, but these did not include enough detail to guide staff.

People's care plans included inconsistent and limited information to guide staff on how people's needs were met. One person's care plan stated in the mobility section that they needed the assistance of one staff member to stand, in the personal care section it stated that they needed two staff. The registered manager told us that this person was living with dementia, however, there was no information about this in their care plan. In the social contacts section it stated that they liked to watch television and read the newspaper. There was no information about what television programmes or newspaper they preferred. This person wore dentures, there was no information about any support they required with them, such as cleaning. The person used continence equipment, there was no information to show who supported the person with this and what support they required. In the person's falls assessment it stated that they may need to use a stand aid, this was not identified in their care plan.

Another person's care plan stated that they could be 'resistant' and 'agitated' when being supported with their personal care. There was no further information about how staff should support them. In another part of their care plan there was reference to the person communicating through body language, there was no further information about what the person communicated and how. The plan also stated that the person had received physiotherapy input and exercised two to three times a day, there was no information about what exercise and who supported the person with this.

Another person's care plan stated that they could be 'verbally and physically aggressive', there was no further information in their care plan about how the staff should support the person with their distress and anxiety, such as de-escalation.

Improvements were needed in people's daily records which identified the care provided to people. These records identified the care tasks provided but they did not all include how people's day had been and their wellbeing.

People's records included their decisions about the care they wanted to receive at the end of their life. For example, if they wanted to be resuscitated, where they wanted to be cared for and any arrangements they had made for their funerals. During our inspection we reviewed the records of a person who was receiving end of life care. The records included that the person's health was deteriorating, but no further information about what and how it was deteriorating. It also stated that the person could not communicate as they did before they became ill, but there was no guidance for staff about how they now communicated and the methods that staff should use to ensure that the person's views were listened to. There was no information about pre-emptive medicines and pain relief. Their daily records and activities records held some days with no entry at all, which did not evidence that the person was receiving good quality end of life care. On one day of the activities records it stated that the person was supported with their mouth care. This is not an activity but a basic care need.

All of the above is a repeated breach of Regulation 9: Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager told us that they were working on improving how to gain people's views about their end of life wishes. They said this was a sensitive subject to raise but they were looking at introducing the discussions in the admission process with people. One person told us that they had a recent bereavement and that the staff supported them during this time, including making arrangements to attend the funeral.

The local authority told us about a safeguarding referral they had received in July 2017 relating to the manager writing in the senior communication book that they wanted the night staff to get a certain amount of people up before the day staff came on duty. During our inspection, we checked the senior

communication book, which did have an entry about the numbers of people the acting manager wanted staff to assist to get up. We discussed this with the registered manager who told us that it was people's choice what time they got up in the morning. We looked at the daily records relating to seven people living in the residential care home. The actual time of events were not recorded, including what time people got up. In addition to the service not being able to evidence the actual times people received care, this also would make it difficult for staff to track people's wellbeing and any changes in their usual routines.

We spoke with people about if they felt their choices were respected relating to the times they got up in the morning and went to bed. One person said, "In the mornings about 7.30am they [staff] come into the room and say 'Are you getting up now?' I feel I have to get up even though sometimes I would like a little bit longer in bed." Another person told us, "When I want to get up I call them [staff], sometimes I have to wait as they are busy with other people here." Another person commented, "They seem to get me up when I want to but in the evenings the staff want to put me to bed before 10pm, sometimes I want to stay up to want to watch TV so I sit in my pyjamas then call the night staff to put me to bed." Two other people told us, "They don't make you get up, I like a lie-in. In the evenings we stay up, if it's interesting we watch it [television]," and, "They ask us what time we like to get up in the morning, it's normally close to 8.30am [preferred time]. They might come at 8am but they say if you're not ready we'll come back later."

People told us that they felt that they were cared for and their needs were met. One person said, "There's always two or three [staff], they talk to you. I don't like being alone, I've made friends here, this is like being at home." Another person told us, "I'm exceptionally well looked after here." One person's relative commented, "The location, the grounds, animals and the general care, I think this is the best one [care home] in Lowestoft."

With their permission, we visited three people who used the domiciliary care service. We reviewed their care plans and in contrast to the issues identified with the care plans in the residential care home, we found that they included step by step instructions for staff on the support needed and tasks they needed to complete to meet people's needs. One of the care plans identified how the service had responded to the person's needs. The person had increased visits and there was a clear timeline as to why this had happened and what they needed extra support with. The manager of the domiciliary care service showed us some new care plans they were working on which were even more detailed. One person said about the service they were provided with, "I am very happy." Another commented, "I'm very well looked after."

People told us that there were social events that they could participate in. One person said, "I don't go out, I like staying in my room. They [staff)] tell me what's going on. If there's anything on [activities] they come and get me in the wheelchair." Another person commented, "They have a [religious] service here which I go to." Another person said, "We have a leisure time in the afternoons. I think they're doing flower arranging now, all sorts of things we do." One person's relative said, "They keep them entertained, they have carpet bowls, bingo."

However, some people said that the activities were not meeting with their interests and choices. One person said, "I'd like to go across to the church [across the road from the service], my [relatives] are buried there." The person told us they could not recall having ever been taken by staff to visit their relative's graves. Another person commented, "It can be a bit boring, it's quite a long day." Another person said, "They have different activities each day but I don't always join in…sometimes I like time to myself in my room."

The service had its own minibus. One person told us, "I've been on one bus trip…it was alright. Yes I would go again." Another person said, "We've got a community bus, they'll ask us where we would like to go."

People had made Easter bonnets. On the first day of our inspection one person told us, "The owner [name of the managing director] will judge the [Easter] bonnets competition to decide who this year's winner will be." On the second day we saw several Easter bonnets lined up on a window sill with cards on them identifying who the winner was.

We saw people participating in activities. A staff member was doing a word search puzzle with a person. A group of people were doing flower arranging. Two people baked brownies and cookies, when they were cooked they were offered around to people. We saw a person playing the organ in the library which was being enjoyed by another two people on the second day of our inspection.

However, we also saw that some people were disengaged. On the first day of our inspection we saw a person walking around the service looking for their children. As the day progressed they became more anxious, asking people and us if we had seen their children. When they told a member of staff that they could not find their children, the staff member told them not to worry and to keep looking. Whilst they did not contradict the person, they did little to offer them reassurance. Another person asked us what time the buses were because they were waiting to go home, this was overheard by a staff member who spoke kindly with the person and offered the person a drink or if they wanted to play cards. The person said they did not want to do any of the things on offer and another staff member asked the person if they wanted to spend some time with them. The person agreed and went with the staff member. However shortly after this the person was sitting alone with a cup of tea on a table next to them. As we passed they asked us about the bus times and said they wanted to go home. Although staff had initially provided support to the person this was not consistently provided.

On the first day of our inspection a person arrived in the library, where there was a large television. They told us about the television programmes they usually watched every afternoon. They said that the remote control had gone missing so they needed to ask staff to put the television on, they said, "Sorry, I feel like a nuisance." We found a staff member and they put the television on the channel the person wanted to watch. We fed back to the provider about the remote control and how the person could have independently watched their programmes and turned over the channels when they wanted. On the second day of our inspection, we asked staff if a remote control had been purchased, they said they did not know but said that it kept going missing.

One person told us that a staff member offered to go to the shops for them when needed, including buying greetings cards, which they described as, "A great help."

We spoke with the activities manager who told us there were currently three staff allocated to the activities role. They worked 28 hours over four weekdays, one staff member worked full time Monday to Friday, and the other 20 hours. They explained that the team had been together for a year, and although well established, they were constantly improving. Their own time was split between two days on the dementia unit and two days in the rest of the residential care home. They told us about the range of activities provided to people by the team, and also equipment that was made available to the other staff to use with people in the activity team's absence. They said that there was a committee of people in the service who came up with their own ideas of the activities they wanted. The activities manager told us that they attempted to see all people at least once a day and involve them in one to one activities if they did not want to participate in group activities.

People told us that they knew how to make a complaint and that they were confident that their concerns and complaints would be addressed. One person said, "I have had no reason to complain but I would speak up if I did." Another person commented, "I haven't heard anyone complain about this place." There was a

complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. Records showed that people's complaints and concerns were investigated and responded to in line with the provider's complaints procedure.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection of 30 November 2016, Well-led was rated Requires Improvement. We found a breach Regulation 17: Good governance of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. This was because improvements were needed in how the service monitored and assessed the care and support provided to people. The provider wrote to us to tell us about the improvements they planned to make. However, at this inspection we found that there were still shortfalls and there was a continued breach of Regulation 17: Good governance of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. In addition the service had failed to make adequate improvements overall to ensure people were receiving safe and good quality care at all times. Therefore Well-led was rated Inadequate.

We were so concerned about how the safety in the service was managed we wrote to the provider following our inspection identifying our intentions if improvements were not made. The provider sent us updated risk assessments for people who were at risk of choking, falls and pressure ulcers. They also sent us an action plan which identified how they intended to improve the service. This included making changes in the management of the service, setting up a working party to improve care planning and purchasing a computerised care planning system. However, the latter two were identified in planned improvements in their last improvement plan. We will continue to monitor the improvements made by this service.

The registered manager told us that they would be stepping down from their role and they were undertaking the head of care position. They had not yet submitted an application to cancel their registration. They said that this would be done when the acting manager of the residential care home had submitted their registered manager application. The registered manager understood that as a registered person they had legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service was run. In addition the registered manager told us that they had changed their surname, we had not been formally notified. The acting manager told us that they had plans to register, there was no clear date when this would be done, they had been in post for a year. They said that they were working on a qualification relevant to the registered manager role.

There are incidents that the provider is required to notify us of by law. This is so we can assess actions had been taken by the service to ensure people are safe. We found that we had not been notified of all of the incidents that had happened in the service. This included incidents in February, April and July 2017 where three people had sustained broken bones.

The governance systems in place were not robust enough for the service's management team to identify shortfalls and take action to address them. For example, care plan audits had not picked up the issues we had identified relating to care planning and risk assessments. In addition the service had failed to make improvements following our previous inspection. The medicines audits that had been undertaken which had identified shortfalls but there was no action plan or records of what actions were being taken to address them.

The systems in place to monitor people's falls were not robust. There was no analysis to identify patterns and trends and systems to make amendments to people's care and/or the environment to reduce the falls.

This was a repeated breach of Regulation 17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People in the residential care home we spoke with did not have a clear understanding about the roles of the management team but did say that they were approachable and visible in the service. One person said, "I am always seeing the manager [but this was the managing director] he's very approachable." Another person commented, "[Acting manager] says good morning to everybody, and the boss [managing director], I think [they] come in every day. In the bad weather [managing director] was ferrying them [staff] in. [Managing director] is hands on." Another person said, "I have met [managing director], they knew [family member] was in hospital… they all come to see me from the office."

A person who used the domiciliary care service told us about the manager, "[Manager of the domiciliary care service] is very good, [they] visit me regularly and [they] know me and what I like." This was confirmed in the interactions we observed between the manager and this person. The manager of the domiciliary care service told us how they had got to know people and had provided care and support to allow them to do this. In addition they had got to know the care staff and observed the work practice of staff to ensure people's needs were met.

The human resource director told us that they had used a consultancy service to assist with improvements in the service. However, we were not provided with a report or the action plan relating to this.

People and relatives were involved in developing the service and were provided with the opportunity to share their views. This included quality assurance questionnaires. We reviewed the received questionnaires from 2017 and found that these were mainly positive. People also had the opportunity to share their views in meetings. The minutes of meetings in showed that they made decisions about the activities they wanted. People we spoke with gave varying comments about the meetings, some knew that they happened and others did not. One person's relative said, "There is a sheet with the activities for the week on there and there is a newsletter I sometimes see, but I have not been to any meetings." One person told us, "They do have meetings and you can put down requests." Another person said, "They have resident's meetings, are you satisfied with how your room is being looked after, that sort of thing."

Staff understood their roles and responsibilities in providing good quality and safe care to people. Staff told us that they could go to the management team and managing director if they needed any advice or support. Staff meetings were held where they discussed the service and any changes in people's needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care This is a repeated breach or Regulation 9. People's care was not appropriately assessed, planned for and met. Care plans did not detail people's specific care needs or guide staff to how these are met. Regulation 9 (1) (a) (b) (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The systems in place were not robust enough to reduce the risks of people being malnourished or dehydrated. Regulation 14 (1) (2) (a) (b) (4) (a)

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 systems in place for assessing and mitigating risks to people were not robust enough to provide people with safe care at all times. Regulation 12 (1) (2) (a) (b) (g)

The enforcement action we took:

We imposed positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This is a repeated breach of Regulation 17. The provider had failed to make improvements. The systems for monitoring and improving the service were not robust enough to identify and address shortfalls in the service provision. Regulation 17 (1) (2) (a) (b) (f)

The enforcement action we took:

We imposed positive conditions.