Tonbridge Care Ltd

Chestnut Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 19 November 2018. The inspection was unannounced. Chestnut Lodge Care 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 regulates both the premises and the care provided, and both were looked at during this inspection.

Chestnut Lodge Care Home is registered to provide accommodation and personal care for 60 older people and people who live with dementia. There were 33 people living in the service at the time of our inspection visit.

The service was run by a company who was the registered provider. The former registered manager had left her post shortly before the inspection. The registered provider had appointed a new manager who was in post and who had applied to us to become the registered manager. 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 the last inspection on 3 April 2018 the overall rating of the service was, 'Inadequate' as a result of which the service was placed into 'special measures'. We found that there were seven breaches of regulations. This was because there were serious shortfalls in the arrangements that had been made to provide people with safe care and treatment. This included oversights that had reduced the level of fire safety protection in the service and in the arrangements to prevent avoidable accidents. There were also shortfalls in that sufficient care staff had not always been deployed to enable people to promptly receive all the care they needed and had the right to expect. In addition to this, the registered provider had not robustly completed background checks on all new members of staff to ensure that they were suitable and trustworthy people to be employed in the service. Another breach of regulations had occurred because there were defects in the accommodation that had resulted for poor maintenance. Further breaches of regulations had occurred because people had not always received person-centred care and had not always had their dignity promoted. The last breach of regulations was because there were serious shortfalls in the systems and processes used to monitor and improve the service including consulting with people to obtain feedback about suggested improvements.

We told the registered provider to send us each month an action plan stating what improvements they had made and intended to make to address our concerns. The registered provider complied with this requirement.

At the present inspection we found that sufficient progress had been achieved to meet all of the breaches of regulations. Sufficient provision had been made to provide safe care and treatment. However, more progress still needed to be made to ensure that one person's medicines were administered in the right way. In addition to this, further developments were needed to enable the service to learn from the occurrence of

accidents and incidents so that steps could be taken to reduce the likelihood of the same thing happening again. Although on most days the number of care staff on duty had been increased there were still occasions when the registered provider had not deployed all of the care staff they considered to be necessary. Suitable arrangements were in place to recruit and select new members of staff. Although on most occasions people received person-centred care that promoted their dignity more needed to be done to address shortfalls. In practice, people were consulted about the care they received. However, more still needed to be done to provide people with user-friendly information to support them to make and review decisions about their care. Significant improvements had been made to the accommodation but additional improvements were still required. The systems and processes used to assess and monitor the operation of the service had been strengthened. However, additional steps needed to be taken to ensure the progress made in the service was further developed and sustained.

Our other findings were as follows. Suitable arrangements had not been made to ensure that three medicines were managed in line with national guidelines. Good standards of hygiene were achieved to prevent and control the risk of infection.

Appropriate arrangements were in place that were designed to assess people's needs and choices so that care achieved effective outcomes. This included providing people with the reassurance they needed if they became distressed. Care staff knew how to provide practical assistance for people in the right way and had received training and guidance. People were helped to eat and drink enough to maintain a balanced diet. Suitable provision had been made to help people receive coordinated care when they moved between different services. People had been supported to access all of the healthcare services they needed. Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

People had been supported by relatives and representatives to express their views about things that were important to them. This included them having access to lay advocates if necessary. Confidential information was kept private.

People received practical assistance to complete everyday tasks and suitable arrangements had been made to promote equality and diversity. There were arrangements in place to investigate and resolve complaints as quickly as possible. Suitable steps had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

The manager had promoted an open and inclusive culture in the service. Suitable arrangements had been made to ensure that regulatory requirements were met. The manager was actively working in partnership with other agencies to support the development of joined-up care.

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 consistently safe.

Sufficient provision had not been made to enable lessons to quickly be learned when things had gone wrong so that people received safe care and treatment.

Suitable arrangements had not been made to ensure that three medicines were managed in line with national guidelines.

Sufficient care staff had not always deployed in the service.

People were safeguarded from the risk of abuse.

Background checks had been completed for new care staff.

People were protected by the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The accommodation was not designed, adapted and decorated to fully meet people's needs and wishes.

Care staff had received training and support that was designed to enable them to provide care in line with national guidance.

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

People were assisted to receive coordinated care and to access ongoing healthcare support.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive person-centred care.

People's dignity was not always promoted.

People were supported by relatives and representatives to express their views about things that were important to them.

Confidential information was managed in the right way.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not been provided with sufficient opportunities to pursue their hobbies and interests.

People were not fully supported to make and review decisions about their care.

Care staff recognised the importance of promoting equality and diversity by supporting people to make lifestyle choices.

There were arrangements to listen and respond to people's complaints to improve the service.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality checks had not always resulted in shortfalls quickly being put right.

There was no registered manager.

Care staff had been supported to understand their responsibilities so that risks and regulatory requirements were met.

The service worked in partnership with other agencies to promote the delivery of joined-up care.

Chestnut Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider continued to meet 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.

Due to technical problems, the registered provider was not able to complete a Provider Information Return. This is information we require registered providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We examined other information we held about the service. This included notifications of incidents that the registered provider had sent us since our last inspection. These are events that happened in the service that the registered provider is required to tell us about. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 19 November 2018 and the inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

During the inspection visit we spoke with 16 people who lived in the service. We also spoke with three care staff, a team leader, two senior care staff, one of the activities coordinators and the deputy manager. In addition to this, we spoke with the manager and with the operations director for elderly services and regulations ('the operations director'). The operations director was based in the service and was responsible for supervising the work of the manager. We observed care that was provided in communal areas and looked at the care records for nine people. We also looked at records that related to how the service was managed including health and safety, staffing, training and quality assurance.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us.

After the inspection visit we spoke by telephone with four relatives.

Requires Improvement

Is the service safe?

Our findings

At the inspection on 3 April 2018 we found that there was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because suitable arrangements had not consistently been made to provide people with safe care and treatment. There were shortfalls in the level of fire safety protection in the service due to defects in some fire safety equipment. In addition to this, suitable steps had not been taken to remove avoidable trip hazards and we found that a number of toilet seats were loose and slid to one side as soon as any pressure was put on them. Furthermore, a member of staff brought their pet dog into work and we saw the animal running around, getting under people's feet and almost causing people to lose their balance. Another shortfall was insufficient provision that had been made to ensure that people only used the garden on their own when it was safe for them to do so. A further problem involved an electric light that was too dim to illuminate a bathroom to a normal domestic standard and also the lights in one bedroom did not work at all. In addition to these defects we found that some windows were not fitted with safety latches in line with national guidance. This oversight had increased the risk of people falling from the windows concerned if they opened them in the wrong way.

After the inspection the registered provider sent us monthly action plans describing what improvements they had made to put right each of the shortfalls and to address the breach of the regulation in question.

At the present inspection we found that action had been taken to address most of our concerns. This was because risks to people's safety had been more robustly assessed, monitored and managed so they were supported to stay safe while their freedom was respected. The manager showed us documents which showed that shortfalls in the service's fire safety regime had been addressed. We saw that avoidable trip hazards had been put right, toilet seats had been securely fixed to the water closets and the electric lighting provided a suitable level of illumination. We also noted that safety latches had been fitted to the three windows we checked.

The manager had strengthened the arrangements used to analyse accidents and near misses so that lessons could be learned to help keep people safe. This had been done so that they could more robustly establish why they had occurred and what needed to be done to help prevent a recurrence. An example of this was people who were at risk of falling being referred to specialist health care professionals so that care staff could be advised about how best to keep the people concerned safe. However, we noted that one of the two patio doors leading to the main garden did not fit into its surround properly. Care staff told us that as a result it was not always possible to switch on the alarm that was in place to notify them to occasions when a person wanted to go into the garden. In turn, this increased the risk that a person might go into the garden on their own when it was not safe for them to do so. We raised our concerns about this matter with the manager and the operations director. They assured us that steps would quickly be taken to address the shortfall.

Nevertheless, there were other examples of risks being managed in the right way to keep people safe. Hot water was temperature controlled and radiators were fitted with guards to reduce the risk of scalds and burns. We also noted that personal care was provided in a safe way. This included people who were at risk of

developing sore skin were being helped to keep their skin healthy and people being supported in the right way to promote their continence.

The registered provider had made sufficient provision to provide people with safe care and treatment and this had resulted in the breach of regulations being met. However, more progress was still needed to address the shortfalls relating to the prevention of avoidable accidents. In addition to this, we needed more reassurance that the progress made would be embedded and sustained.

At the inspection on 3 April 2018 we found that there was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider was not operating robust recruitment and selection procedures. There were shortfalls in the checks that had been completed to establish that two new care staff were suitable and trustworthy people to be employed in the service. Although other checks had been completed including obtaining clearances from the Disclosure and Barring Service, the shortfalls we found had increased the risk that people would not receive safe care. This was because there was a greater likelihood that applicants would be appointed to work in the service who were not suitable to have unsupervised contact with the people who lived in the service.

After the inspection the registered provider sent us monthly action plans describing what improvements they had made to put right each of the shortfalls and to address the breach of the regulation in question.

At the present inspection we noted that no new care staff had been appointed since our inspection on 3 April 2018. However, documents showed that new and more robust systems and processes had been introduced to ensure that suitable enquiries would be made to establish all future applicants' previous good conduct before a decision was made about making an offer of employment. These arrangements included obtaining a full and continuous employment history. This is necessary so that registered providers can make informed decisions about any enquiries they may need to make with an applicant's past employers to establish the person's good conduct. In addition to this, we noted that suitable provision remained in place to obtain disclosures from the Disclosure and Barring Service. These checks are important to establish if an applicant has a relevant criminal conviction or has been included on a barring list due to professional misconduct.

The registered provider had made suitable provision to ensure that only fit and proper people were employed to work in the service. This had resulted in the breach of regulations being met. However, we needed more reassurance about how these revised arrangements would work in practice. In addition to this, we needed more reassurance that any progress made would be embedded and sustained.

Most of the arrangements used to manage medicines enabled care staff to safely administer them in line with national guidance. There was a sufficient supply of medicines that were stored securely in temperature-controlled conditions. Care staff who administered medicines had received training. We saw them correctly following the registered provider's written guidance to make sure that people were given the right medicines at the right times. When medicines were no longer needed they were disposed of safely. However, we noted that robust arrangements had not been made to administer three medicines to a person whose doctor had said could be given covertly in a warm drink. This was because the manager had not checked with a pharmacist to establish that the medicines in question were suitable for use in this way and would not lose their therapeutic effect. We raised this matter with the manager who told us that advice from a pharmacist would immediately be obtained and that any necessary changes to the administration of the medicines would be made.

At the inspection on 3 April 2018 we found that the registered provider had not made robust arrangements

to ensure that sufficient care staff were routinely deployed in the service. They had not used a nationally recognised system to calculate the number of care staff who needed to be on duty at any particular time of day to promptly provide people with the care they needed. As a result we could not be confident that changes in people's needs for care would quickly be identified and reflected in the number of care staff deployed in the service. In addition to this, on some days suitable provision had not been made to deploy enough care staff to meet the minimum level specified on the staff roster. We also found that even when the service was fully staffed care staff were not always being deployed in the right way. This was because there were occasions on which there were insufficient care staff available to provide people with the individual assistance they needed. This was particularly the case at lunchtime when we saw some care workers completing administrative duties rather than helping people to dine in comfort. We recommended that the registered provider use a recognised tool to calculate how many care staff needed to be on duty and how this resource should best deployed to ensure that people consistently received person-centred care.

At this inspection we found that the manager and operations director had reviewed the number of care staff who needed to be deployed in the service. They described to us how when doing this they had taken into account the number of people living in the service and the care they needed. Although they had not recorded this process and had not referred to a nationally recognised model we found that on the day of the inspection sufficient care staff were on duty. This was because we saw people promptly receiving a wide range of practical assistance with everyday tasks such as washing and dressing and going to the bathroom. Nevertheless, when we examined records of the care staff who had been deployed in the service during the seven days preceding the date of the inspection visit we found that on two of the days there had been limited amounts of time when care shifts had not been filled. The manager told us that the vacant shifts had occurred because a member of care staff had been off work due to ill health and that it had not been possible to arrange cover at short notice. They said that on most occasions vacant care shifts were filled by using agency staff or through colleagues working overtime. Nevertheless, the manager and operations director accepted that further steps needed to be taken to establish more effective back-up systems such as having their own bank staff and/or quicker access to agency staff. This was necessary to ensure that care staff were deployed in the service to meet the minimum requirement set by the registered provider.

People told us they felt safe living in the service. One of them said, "Yes, everything here makes me feel safe. It's very nice and comfortable." A person who lived with dementia and who had special communication needs smiled and waved in the direction of a passing member of staff when we used sign assisted language to ask them about their experience of living in the service. Relatives were also complimentary about the service. One of them remarked, "I think that Chestnut Lodge is very good now. Things are more settled and much better since the change at the top."

We found that people were suitably safeguarded from situations in which they may experience abuse. Records showed that care staff had received training and knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They told us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm. The manager said and records confirmed that they had carefully considered each occasion when a person had sustained a minor injury such as a bruise. This was so that the causes of each injury could quickly be established and if necessary action taken to keep the person safe. In addition to this, the registered provider had established suitable arrangements to assist people to manage their personal spending money if asked to do so. This included the deputy manager keeping an accurate record of any money spent on behalf of people so that there was a clear account to which people and their relatives could refer. This arrangement contributed to protecting people from the risk of financial mistreatment.

At the inspection on 3 April 2018 we found that an area of carpet in one of the lounges was dirty and heavily

stained. Also, the handrails fitted in one of the showers were rusty and so could not be cleaned properly. This was also the case with 10 of the wall tiles fitted in the shower's enclosure. They were badly cracked and their damaged surface was discoloured with grime. All of these defects had increased the likelihood that people would acquire avoidable infections that would compromise their health. At the present inspection we found that these defects had been addressed. In addition to this, records showed that the administrator had completed a regular and more detailed audit to ensure that good standards of hygiene were maintained to prevent and control infection. The accommodation had a fresh atmosphere and that soft furnishings, beds and bed linen had been kept in a hygienic condition. Furthermore, care staff recognised the importance of preventing cross infection. They regularly washed their hands using anti-bacterial soap and wore disposable gloves when assisting people with close personal care.

Requires Improvement

Is the service effective?

Our findings

At the inspection on 3 April 2018 we found that there was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the accommodation was not designed, adapted and decorated to meet people's needs and expectations. Suitable steps had not been taken to support people who lived with dementia to find their way around their home. Although signs were fitted to bathroom and toilet doors these did not use easy-to-understand graphics that are often helpful for people who live with dementia. In addition to this, little had been done to distinguish most people's bedroom doors so that there was less risk of them entering the wrong room. We also found that people had not been offered the opportunity to have locks fitted to the their bedroom doors to enable them to secure their personal space. Furthermore, some bedroom doors and one of the doors leading to a communal bathroom were scratched and looked unsightly. Also, the ceiling in one of the bedroom's en-suite bathrooms had been partially removed leaving pipework and electrical wires exposed. A further problem was that the garden was not an attractive space. This was because one of the perimeter fences was damaged and there was litter and broken flower pots strewn over the lawns. Although there was a fish pond this area was littered and the water was green with mould.

After the inspection the registered provider sent us monthly action plans describing what improvements they had made to put right each of the shortfalls and to address the breach of the regulation in question.

At the present inspection we found that all of the shortfalls had been addressed. We also noted that a new and more robust system had been introduced to identify and quickly resolve defects in the accommodation. However, although a significant amount of work had been undertaken since our last inspection to completely refurbish eight bedrooms, we found that further improvements still needed to be made. These included the redecoration of the dining room where we saw that on one of the walls some of wallpaper had been stripped off. Although the manager said that this had been done as the room was being prepared for redecoration, nevertheless the room looked unsightly. In addition to this, the manager could not tell us when the work would be completed.

The registered provider had made sufficient provision to design and adapt the accommodation to meet people's needs and expectations. This had resulted in the breach of regulations being met. However, more progress was still needed to address the shortfall in the redecoration of the dining room. In addition to this, we needed more reassurance that progress made in relation the maintenance of the accommodation would be embedded and sustained.

At the inspection on 3 April 2018 we found that there was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some people were not being supported to eat and drink enough to maintain a balanced diet. We were present when the lunchtime meal was served and we saw that three people did not receive the individual assistance they needed in order to enjoy their meal. This resulted in the three people concerned being at increased risk of not eating and/or drinking enough to maintain their health. There were also shortfalls in the provision that had been made to support two of the people whom a healthcare professional had said needed extra help to eat and drink

enough. One person needed to have their intake of food and fluid carefully monitored to ensure that they were taking enough nutrition and hydration. The other person needed to be offered regular snacks to maintain their body weight at a safe level. We found that neither of these people were receiving the right care. In relation to one person the food and fluid diary was incomplete and there was no evidence the other person was being offered regular snacks. We also saw that the dining tables were not attractively laid out and did not have tablecloths and condiments. These shortfalls had increased the likelihood that people would not enjoy their experience of dining in the service leading to them being at greater risk of not eating and drinking enough.

After the inspection the registered provider sent us monthly action plans describing what improvements they had made to put right each of the shortfalls and to address the breach of the regulation in question.

At this inspection people told us that they enjoyed their meals. One person remarked, "The food is really nice." Another person said, "We get more than enough food here." Records showed that more care staff were regularly being deployed in the dining room at lunchtime. We saw that this resulted in people more promptly receiving individual assistance to dine when necessary. The menu showed that there was a choice of dish served at each meal time and alternatives to the menu were also provided. The dining tables were neatly laid with a tablecloths and condiments. The meals we saw served at lunchtime were attractively presented and the portions were a reasonable size.

We also found that more robust arrangements had been introduced to follow healthcare professionals' advice when a person needed additional support to eat and drink enough to maintain a balanced diet. Records showed that people had been offered the opportunity to have their body weight measured. This was so that any significant changes could be noted and referred to a healthcare professional. As a result, some people had been prescribed a food supplement that was designed to help them increase and/or maintain their weight. Other people were having their intake of nutrition and hydration monitored in the right way so that action could quickly be taken if they were not eating and drinking enough. Furthermore, the manager had liaised with healthcare professionals when people needed extra assistance because they were at risk of choking. This included the people concerned being offered the opportunity to have their food and drinks modified so that they were easier to swallow.

The registered provider had made sufficient provision to provide people with safe care and treatment so that they had enough nutrition and hydration and this had resulted in the breach of regulations being met. However, we needed more reassurance that the progress made would be embedded and sustained.

At the inspection on 3 April 2018 we found that there was a breach of regulations because suitable provision had not been made to provide care staff with all the training and guidance they needed. This shortfall was reflected in some care staff not having all the competencies they needed to provide safe care and treatment. We were concerned to observe three occasions on which some care staff did not recognise when people who lived with dementia needed assistance, was asking for help and was becoming upset.

After the inspection the registered provider sent us monthly action plans describing what improvements they had made to put right each of the shortfalls and to address the breach of the regulation in question.

At the present inspection we found that care staff had been provided with additional training and guidance. This was designed to enable them to provide care in the right way. Records showed that care staff had received training in key subjects such as how to safely assist people who had physical adaptive needs, how to help people keep their skin healthy and how to support people to promote their continence. It also included how to respond effectively to the care needs of people who lived with dementia and who may

express themselves in ways that could result in injury to themselves and others around them. We observed care staff when they were assisting people and we asked them questions to assess key parts of their knowledge. We saw three occasions on which care staff assisted people who had reduced mobility. This assistance was provided in the right way including the correct use of hoists and other specialist equipment. We also saw people being helped to relieve pressure on their skin by repositioning themselves and by using special soft cushions and mattresses.

In addition to this, we observed two occasions on which care staff responded appropriately when a person became distressed and needed reassurance to keep themselves and others around them safe. One of these occasions involved care staff gently reminding a person that sitting down in a hallway was likely to result in another person living in the service bumping into them and causing upset. The person was able to use this advice and shortly after they decided to leave the hallway and go to the conservatory where they sat in a comfortable armchair.

We asked four care staff about the training and guidance they had received. All of them said that they were satisfied with the way in which they had been supported to care for people. This included meeting with a senior member of staff to review their performance and to plan for their professional development.

However, there were still examples of people not always receiving all the care they needed. We saw that two people had not been supported to regularly wash their hair. As a result, their hair looked very greasy and did not enable the people to present themselves in a dignified way. We asked two care staff about this matter and found that little had been done to engage the people concerned in a gentle conversation about how they wished to be supported to maintain this aspect of their personal hygiene. Another example was a person who declined to be assisted by a member of care staff to change an item of clothing that had become stained with food. Again, the member of care staff did not attempt to engage the person in considering the matter further. This resulted in the person wearing the garment from lunchtime when we first saw them to 4 o'clock in the afternoon when we saw them last. We raised these concerns with the manager who assured us that additional steps would be taken to better support the people concerned to maintain their appearance in a way that promoted their dignity.

The registered provider had deployed sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, further progress still needed to be made to ensure that all care staff had the knowledge and skills they needed to engage people who lived with dementia in maintaining their hygiene and appearance. In addition to this, we needed more reassurance that progress made in relation the provision of training and guidance would be embedded and sustained.

People told us they were confident that care staff knew what they were doing and had had their best interests at heart. One of them said, "The staff seem pretty able. Staff seem okay. I think they understand how to help me." Relatives were also confident that the service was run in an effective way. One of them told us, "On balance the service is quite good. I have always found my family member to be neat and clean and well in themselves whenever I've called to see them."

No one had moved into the service since the inspection on 3 April 2018. However, we found that the manager understood the importance of carefully establishing what assistance a person needed and wanted to receive before they moved into the service. This was to make sure that the service had the necessary facilities and resources. In addition to this, the manager recognised that additional provision that might need to be made to ensure that people did not experience discrimination. The manager said that this included carefully asking people if they had expectations deriving from cultural or ethnic identities about

how their close personal care should be provided and who should deliver it.

Shortly before our inspection visit a shortfall had occurred in the arrangements made to ensure that people received effective and coordinated care when they were referred to or moved between services. This was because when it had been necessary for a person to be admitted to hospital care staff had not provided hospital staff with a suitably detailed account of the person's care needs. This had increased the risk that the person concerned would not quickly receive all the medical assistance they needed. The manager showed us evidence that robust steps had been taken to ensure that this mistake did not occur again. This included the preparation of a new and more detailed summary of each person's care needs that the manager said would immediately be given to ambulance and hospital staff.

People were supported to live healthier lives by receiving ongoing healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dietitians.

There were suitable systems and processes in place to ensure that national guidelines were followed to promote positive outcomes for people by seeking consent to care and treatment in line with legislation. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law 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 make 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 in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered provider was working within the principles of the Mental Capacity Act 2005 by applying to obtain authorisations to deprive a person of their liberty when necessary. Also, we checked whether the registered provider had ensured that any conditions on authorisations were met.

We found that people had been consulted about key parts of the care they received and had consented to its provision. This included making decisions about subjects such as when they wanted to be assisted to have a bath or shower, when they wanted to spend time in the privacy of their bedroom and where they wished to eat their meals. We also noted that the registered provider had correctly established when a person lacked the necessary mental capacity to make decisions about important things that affected them. When this had occurred they had involved key people in a person's life to help to ensure that decisions were taken in their best interests.

Records showed that the registered provider had made the necessary applications for DoLS authorisations. Furthermore, they had carefully checked to make sure that any conditions placed on the authorisations were being met. These measures helped to ensure that people who lived in the service only received lawful care that was the least restrictive possible.

Requires Improvement

Is the service caring?

Our findings

At the inspection on 3 April 2018 we found there was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because suitable arrangements had not been made to ensure that people consistently received care that promoted their dignity. The examples we saw included a person not having been assisted to button-up their clothes properly resulting in their undergarments being visible. We also saw people not being assisted to handle everyday objects in the right way such as a paintbrush being mistaken for a straw. In addition to this, we observed an occasion when a member of care staff assisted a person to stand by pulling on the seat of their trousers in a disrespectful way. A further concern was occasions on which some care staff spoke with people who lived in the service in a manner that was likely to be experienced as abrupt and unkind. We also found that suitable provision had not been made to promote people's privacy. This was because one of the communal bathrooms did not have a lock on the door and so could not be secured when in use. We also witnessed an occasion in one of the communal areas when a member of care staff spoke loudly with a person about their medical condition and in effect disclosed the information concerned to a number of other people who were sitting nearby.

After the inspection the registered provider sent us monthly action plans describing what improvements they had made to put right each of the shortfalls and to address the breach of the regulation in question.

At the present inspection we found that most of the necessary arrangements had been made to promote people's dignity. We saw that people had been assisted to correctly fasten their clothes. We also saw that care staff were assisting people to use everyday objects in the right way. An example of this was an occasion on which a person attempted to use a fork when eating their pudding. A member of care staff gently suggested that the person use a spoon which they then did. In addition to this, we witnessed a large number of occasions on which care staff spoke with people living in the service. We noted that care staff were consistently courteous, polite and helpful. We checked three communal bathrooms and found that each had a working lock on the door. In addition to this, we noted that care staff only discussed people's individual care needs in a discreet way that was unlikely to be overheard by anyone else. We also noted that the manager and operations director had appointed a senior member of staff to directly observe the delivery of care. This was so they could provide practical guidance to colleagues when problems occurred so that things could be done better in the future to ensure that people received care that consistently met their expectations.

However, one person told us that they were not satisfied with the arrangements that had been made for them to colour their hair. They said that a hairdresser had not called to the service for several weeks resulting in them not being able to have their hair recoloured. In addition to this, two other people told us that some care staff did not always asked them what clothes they wanted to be put out for them to wear each day. Nevertheless, most people were positive about the care they received. One of them said, "The staff are very caring and they're cheerful." Another person told us, "They are very caring. I have never seen anybody not treated well." A person who lived with dementia and who had special communication needs smiled and went across the room to hold hands with a member of care staff when we asked them about the care they received. Relatives were also positive in their feedback. One of them said, "I like visiting the service

because it's always so friendly. You asked me if the service is caring and my response is that my family member's face lights up with joy when they see one of the carers. They beam with joy and you couldn't buy that."

The registered provider had made sufficient provision to ensure that people received care that promoted their dignity and was respectful. This had resulted in the breach of regulations being met. However, more progress still needed to be made to ensure that people could have their hair styled as they wanted and were suitably supported to choose which clothes they wished to wear. In addition to this, we needed more reassurance that the progress made would be embedded and sustained.

Suitable provision had been made to enable people to be supported to express their views about things that were important to them. Most people had family, friends or solicitors who could support them to express their preferences. Furthermore, the manager had developed links with local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes. People could speak with relatives and meet with health and social care professionals in private if this was their wish. Also, care staff had assisted people to keep in touch with their relatives by post and telephone.

There were a number of systems and processes which were designed to ensure that written information was kept confidential. This included paper records that contained private information being stored securely when not in use. Computer records were password protected so that they could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

At the inspection on 3 April 2018 we found a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people had not consistently been provided with person-centred care. People had not been offered sufficient opportunities to pursue their hobbies and interests and to engage in social activities. In addition to this, little had been done to present information in care plans in a user-friendly way by using multi-media tools such as graphics and colours. This oversight had reduced people's ability to be fully involved in the process of making decisions about and reviewing the care they received.

After the inspection the registered provider sent us monthly action plans describing what improvements they had made to put right each of the shortfalls and to address the breach of the regulation in question.

At the present inspection people were positive in the comments they made about the calendar of social activities. One of them said, "I have enough to do. Some days I like to do my own thing, some days I like to sit and chat to staff and other days I'll join in with others if it's something I like doing." We found that people had been offered more opportunities to enjoy pursuing their hobbies and interests. We saw and records confirmed that people had been supported to join other people who lived in the service to participate in games, singing and artwork. The manager said that people were also assisted on an individual basis to enjoy activities such as nail care and reading newspapers and magazines. The manager said that this was necessary because some people did not want or were not able to join in group activities. However, we did not see anyone receiving individual support to enjoy activities. In addition to this, we noted that the provision of individual support was poorly planned. This was because it was not based on an assessment of each person's individual needs and wishes. In practice, people only received individual support as and when one of the two activities coordinators happened to notice that a person appeared to be disengaged with their surroundings.

People told us that they received a lot of practical assistance from care staff and we saw a number of examples of care staff consulting with people about the care they wanted to receive. One of these examples was people being consulted about whether they wanted to have a bath or a shower. Another example was people being asked if they wanted toiletries to be purchased by the service on their behalf.

In addition to this, since the inspection dated 3 April 2018 further progress had been made to meet the Accessible Information Standard that was introduced on 1 August 2016. This measure requires all providers of NHS care and publicly-funded adult social care to make suitable arrangements to support people have information or communication needs relating to physical and/or sensory adaptive needs. It also includes people who live with dementia and who need to have information presented to them in an accessible manner using techniques such large print and graphics. There was a care plan for each person that was designed to describe the care they had agreed to receive. We noted that since the inspection on 3 April 2018 additional steps had been taken to better enable people to access these documents. This was because there was a document called "This is me" that described how each person wanted to be involved in making decisions about their care. The document used a combination of text and graphics to record conversations

that care staff had completed with each person about things to do with the care that were important to them.

The manager told us that each person's care plan was regularly reviewed by care staff. They also said that whenever possible people who lived in the service were actively involved in these reviews. We asked five people about their experience of being involved in reviewing decisions made about their care. Four of them said that they were satisfied with the arrangements that had been made. The fifth person told us that they had asked care staff to liaise with one of their relatives about the care provided for them which they understood had been done.

The registered provider had made sufficient provision to ensure that people received person centred care. This had resulted in the breach of regulations being met. However, more progress still needed to be made to ensure that people were offered a full range of opportunities to pursue their hobbies and interests. In addition to this, we needed more reassurance that the progress made would be embedded and sustained.

Care staff understood the importance of promoting equality and diversity. People were offered the opportunity to meet their spiritual needs by attending a religious ceremony that was regularly held in the service. Care staff also recognised the importance of appropriately supporting people if they followed gay, lesbian, bisexual, transgender or intersex life-course identities. This included being aware of how to help people to access social media sites that reflected and promoted their choices.

There were suitable arrangements to ensure that people's complaints were managed in the right way. People had been informed about their right to make a complaint and how to go about it. Records showed that since the inspection on 3 April 2018 the registered provider had received 10 complaints about the service. The complaints concerned a range of issues relating to the care and facilities provided in the service. We found that the registered provider and/or the manager had investigated each complaint to quickly resolve any concerns so that the service could make any necessary improvements.

Suitable arrangements had been made to support people at the end of their life to have a comfortable, dignified and pain-free death. This included consulting with people and their relatives to establish how best to support a person when they approached the end of their life. A part of this involved clarifying each person's wishes about the medical care they wanted to receive and the religious observances in which they wished to participate.

Requires Improvement

Is the service well-led?

Our findings

At the inspection on 3 April 2018 we found that the registered provider had not established suitable arrangements to assess, monitor and improve the quality and safety of the service. This was because the quality checks that had been completed by the registered provider had not been robust. As a result, shortfalls in the running of the service had not always been identified and quickly resolved. These included oversights in the provision of safe care and treatment, deployment and recruitment of staff, provision of person-centred care that promoted people's dignity and the maintenance of the accommodation. In addition to this, suitable arrangements had not been made to enable people and their relatives to suggest improvements to the service.

After the inspection the registered provider sent us monthly action plans describing what improvements they had made to put right each of the shortfalls and to address the breach of the regulation in question.

At the present inspection we found that the manager and the operations director had strengthened a number of the audits that were already being used in the service at the time of the last inspection. These audits referred to the way in which people who lived in the service were supported to manage their personal spending allowances, completion of background checks for potential new members of staff, management of medicines and the provision of training and guidance for staff. Furthermore, the manager and operations manager had introduced new audits, systems and processes. These included additional checks of the arrangements made to support people who were at risk of not eating and drinking enough to have a balanced diet. In addition to this, new and more robust checks were being completed so that defects in the accommodation could be quickly identified and put right.

However, we found that this more rigorous approach to running the service had not always been effective in quickly resolving continuing shortfalls in the running of the service. These oversights included the prevention of avoidable accidents, management of three medicines, deployment of sufficient and competent care staff, delivery of person-centred and dignified care, maintenance of the accommodation and the provision of opportunities for people to pursue their hobbies and interests. We raised our concerns about these shortfalls in overseeing the operation of the service with the manager and operations director. They assured us that they would continue to focus on introducing, testing and revising new ways of monitoring the running of the service. This included the operations director continuing to be based in the service. The operations director said that they intended to use their time in the service to complete progressively more detailed assessments of how well people's needs and expectations were being met.

We found that a number of arrangements had been made to better support people who lived in the service and their relatives to suggest improvements to be made to the service. Shortly before the present inspection visit the manager had invited people who lived in the service and their relatives to meet with them to discuss how well the service was meeting their needs and expectations. At the meeting the manager had also asked for feedback about how people would like to be consulted in future about the development of the service. As a result of this exercise the manager confirmed to us that regular 'residents' and relatives' meetings would be held. They also said that a new "newsletter" would be sent to everyone every three months to give

an update about developments in the service. In addition to this, we found that people who lived in the service had been consulted on an individual basis about the developments they would like to see put into place. We asked five people about the work that was underway to redecorate the dining room. All of them said that care staff had asked them whether they would like the work to be done and the colour scheme they would like to adopt.

Everyone with whom we spoke considered the service to be well run. Summarising this view a person said, "It runs okay most days. There's the odd hiccup of course with staff but it's okay here and I've no complaints really." Relatives were also complimentary about the management of the service. One of them remarked, "It's definitely better now. Things are more organised. The staff wear easily recognisable uniforms which is a big improvement as before I often didn't know who was who. It's more professional now."

The registered provider had made sufficient provision to monitor, assess and improve the quality of the service. This had resulted in the breach of regulations having been met. However, further progress was still needed to fully develop the systems and processes necessary to identify and quickly resolve shortfalls in the running of the service.

There was no registered manager in post. The former registered manager had left her post shortly before the present inspection. The registered provider had appointed a new manager who was in post and who had applied to us to become the registered manager. 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.

There were a number of systems and processes in place to support care staff to understand and manage risks and to comply with regulatory requirements. This included there being a senior person on duty who was in charge of each shift. Also, care staff could contact the manager or the deputy manager during out of office hours if they needed advice or assistance. Care staff had been invited to attend regular staff meetings that were intended to develop their ability to work together as a team. This provision was designed to ensure that care staff were suitably supported to care for people in the right way. These measures all contributed to care staff being suitably supported to care for people in the right way.

The manager and care staff told us there was a 'zero tolerance approach' to any member of staff who did not treat people in the right way. As part of this care staff told us that they were confident that they could speak to the manager and operations director if they had any concerns about people not receiving safe care. They told us they were confident that any concerns they raised would be taken seriously so that action could quickly be taken to keep people safe.

It is a legal requirement that a registered provider's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the registered provider had conspicuously displayed their rating both in the service and on their website.

Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. This is so that we can check that appropriate action has been taken. The manager had submitted notifications to Care Quality Commission in an appropriate and timely manner in line with our guidelines.

The service worked in partnership with other agencies. There were a number of examples to confirm that the

manager and operations director recognised the importance of ensuring that people received 'joined-up' care. One of these involved the manager making arrangements to meet with the managers of other local services to discuss and share ideas about how to promote best practice in the provision of safe care and treatment.