Amson Care Ltd

Shiels Court 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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Shiels Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 40 people in one adapted building. At the time of this inspection there were 37 people living in the service. The service provides accommodation and personal care to people living with dementia and mental ill-health.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
When we completed our previous inspection on 13 and 14 February 2018 we found concerns relating to the deployment of staff throughout the home. We also found that staff were unclear when and how to apply the Mental Capacity Act (MCA) 2005.

At this inspection we found ongoing concerns relating to staffing, training and the application of the MCA. People using the service had been diagnosed with dementia or mental ill-health and most were unable to make safe choices relating to their wellbeing. Care plans did not show how decisions had been reached to ensure they were kept safe. Staff continued to show limited understanding of the relevant procedures and legislation. Some staff had still not received training to ensure they had the right skills and knowledge to meet the needs of people using the service.

We identified concerns around the management of people's safety. Risk assessments relating to people's care needs lacked detail and were not routinely updated. Measures identified to reduce certain risks in the home, such as exposed hot pipes, had not been put in place. Staff recruitment and safeguarding reporting was not consistently robust. Medicines were administered safely but medicine records were not always accurate. Staffing levels did not enable appropriate levels of support at meal times.

The provider had failed to respond to an action plan arising from the previous CQC inspection. This demonstrated shortfalls in the leadership of the service. The service's governance systems required improvement to manage risks and drive improvement. Management did not routinely seek feedback on the service.

Staff did not always have time for meaningful interactions with people. For example, at lunchtime some people did not receive encouragement and support to ensure they ate their food. Care plans were not always up to date and did not contain information about people's end of life care preferences.

Staff sought people's consent before undertaking tasks and they offered people choice with their care. Staff

also supported people to be independent where possible. Staff worked well with other healthcare professionals to ensure people's health care needs were met. Referrals to specialist health care agencies were made promptly, as required. People and relatives reported that staff were kind and caring and they delivered care which responded to people's needs and wishes.

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

This is the third time the service has been rated Requires Improvement.

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.

Risk assessments relating to people's care were not regularly updated.

There were some environmental risks which could place people at risk of harm.

Recruitment procedures needed to be more robust. Staffing levels did not always enable people to receive enough support.

People received their medicines safely, however, some records were not accurate.

Records relating to safeguarding incidents were incomplete and some incidents were not correctly reported.

Is the service effective?

Requires Improvement

The service was not always effective.

Some staff members had not undertaken training relevant to their roles or received regular supervisions.

Staff supported people to access healthcare professionals when needed.

Staff were aware of people's nutritional and hydration needs. People did not always receive enough support at lunchtime.

There were no records relating to people's mental capacity assessments or best interest decisions. Applications to restrict people's liberty for their own safety were poorly documented and managed.

Is the service caring?

Good

The service was caring.

People and their relatives felt staff were kind and caring. Staff knew about people's wishes and preferences.

People were able to make choices about their care. People were encouraged to be independent.

People and their relatives were involved in making decisions about people's care.

There was some evidence that staff treated people with dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always contained uptodate guidance for staff on meeting people's individual needs and preferences.

People's end of life care wishes were not documented.

People's needs and preferences were usually met by staff.

Staff supported people to engage in activity.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager and provider had not responded to the previous CQC inspection report as required.

There were quality assurance systems in place but these were not always effective.

Staff expressed mixed views on the leadership of the service.

The service worked well with external health agencies.

Shiels Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 9 January 2019 and was unannounced. The inspection team consisted of two inspectors, and an expert-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. On this occasion their expertise was in dementia care. The second day of the inspection
was completed by two inspectors.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority quality assurance team prior to the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

To help us assess how people's care needs were being met we reviewed four people's care records and other information, including risk assessments. We also looked at the medicines records for 10 people. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with ten people who lived at the service, six relatives, the registered manager, three care assistants and two senior care assistants, the chef and a visiting health care professional.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in February 2018, we found the service in breach of the regulation relating to staffing. We rated this key question as 'requires improvement'. At this inspection we found some improvements had been made regarding staffing. However, there were other areas which needed further work to ensure people's safety. We identified shortfalls in the assessment and management of risks to people living in the home. We also found the systems in place to ensure people received their medicines correctly were not routinely effective or safe. This key question therefore remains as 'requires improvement'.

People were not routinely protected against safety hazards in the home. This meant they were at risk of harm. We looked in some people's bedrooms and in the communal facilities such as bathrooms, shower room and toilets. We observed exposed pipe work which fed hot water to the radiators and sinks. The hot water from some basins taps in people's rooms was too hot and presented a risk of scalding. We spoke with the maintenance person who told us that the temperature of the hot water in one part of the home was maintained at 55 – 57 degrees. They said that in another part of the home it was even hotter. They also confirmed that there were no temperature control valves in place to control the hot water temperature to the taps.

A legionella assessment had been carried out by an external company and the report we viewed highlighted some areas for improvement. One of which was the water temperatures which were described as low at the boiler. The report recommended that the temperature was increased and that temperature control valves were fitted to reduce the temperature at the hot water taps. This action had not been taken. Other records showed that hot water temperatures had been checked for November and December 2018, the temperatures ranged between 54 and 66 degrees. The Health and Safety Executive recommend that hot water temperature controls should be provided to ensure that water hotter than 44 degrees is not discharged from outlets that may be accessible to vulnerable people. We discussed our concerns about exposed pipe work and hot water temperatures with the registered manager. After the inspection they confirmed that prompt action had been taken to address these risks.

There was an open kitchen area which was designed to promote people's independence. The registered manager told us that some people were able to make their own hot drinks and it was important not to deny them this opportunity. However, the facility needed to be risk assessed. The area contained a fridge, microwave, and a hot water dispenser. There was a cleaning product on the window sill. The accident and incident log for December 2018 showed that one person burnt their finger whilst using the hot water dispenser. The person who burnt their finger was assessed by staff as low-risk due to their early stage dementia. This suggested the kitchen area was not safe for people living in the home to use.

We noted that one person smoked in an outside area at the side of the home. A heavy fire door had to be opened and latched to prevent it from closing shut. We were told that if the door did close, it would be possible to call the kitchen staff through a different door. However, staff were not always in the kitchen. We saw that on occasion the person smoked outside alone and in the dark, yet no related risk assessment had been undertaken. They could potentially be locked outside without being able to access help.

The care files we looked at revealed that people's individual risk assessments were not regularly reviewed. The home created easy reference information packs for carers or for external agencies called 'passports'. These contained an overview of the information in the person's care file and were intended to provide a full picture of their health and care needs. However, they did not contain information relating to each of the potential risks people faced. Staff would therefore not know how to keep people completely safe.

We reviewed the accidents and incidents log for December and November 2018. During this period 24 incidents had been recorded, including 14 falls. Injuries were sustained as a result of seven of these incidents. It was not clear from the log whether action had been taken in each case to prevent further injury or harm. The incident log was generated from the electronic care planning system, which the service introduced in early 2018. Staff told us they had not received any training to use their hand-held devices. Accidents and incidents were not consistently recorded in the log. For example, one person's care file showed they had a fall in December 2018, however this was absent from the log. One care assistant told us they should log incidents on their hand-held device but that they did not know how to. The log was therefore incomplete. This meant that management could not accurately monitor risks to people's safety and any changes in their care needs.

We looked at how the service managed people's medicines and how information in ten people's medication records and care notes supported the safe handling of their medicines.

Senior care staff, team leaders and managers administered medicines to people. Training records indicated that each of these people had received medication training. Five senior care staff had not had their competence assessed though. The competence assessment for one of the managers was unreliable. According to administration records they did not administer medicines on the date they were assessed.

The registered manager told us that the service was in the process of switching to another pharmacy. This had caused some issues with medicines charts not being supplied by the pharmacy. Staff were hand writing some medicines on people's charts and in some instances, they were not recorded correctly. There was also duplication of some medicines on separate charts and medicines starting at different stages in the monthly cycle. The issues with records could potentially lead to errors occurring.

We found that systems were in place to enable staff to monitor medicine administration and their records for most but not all medicines. Documentation indicated that three errors were identified by staff when undertaking their rounds in June and July 2018. Three of these involved patches being missed or applied on the wrong day. The registered manager told us that there had been no further medicine errors since then. They told us that any medicine errors were reported to the doctor.

We found that it was not possible in all cases to audit medicines effectively as the quantity of medicines received or carried forward from the previous cycle was not recorded on the medicines record. We also noted some gaps on the chart where it was not clear whether medicines had been administered or not. The service was carrying out audits and had recently conducted spot checks on medicines but no issues were identified.

When people were prescribed medicines on a when-required basis, there was not always written information to assist staff to give people these medicines appropriately and consistently. When these medicines were given staff did not always record the reason why.

For people with limited mental capacity to make decisions about their care or treatment and who would refuse their medicines, some were given their medicines crushed and hidden in food or drink (covertly).

However, records did not always show who staff had consulted with when decisions had been made to give people their medicines in this way. We noted that guidance had not been obtained from the pharmacist specifically for these medicines to ensure they could be prepared safely. In addition, we noted that there was a lack of written person-centred guidance for staff about how they should prepare people's medicines covertly.

We noted that not all topical medicines were stored securely. These were seen unsecured in people's bedrooms. This meant people were potentially at risk of harm if the medicines were misused or accidently ingested.

These findings described above demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staffing levels and the deployment of staff contributed to an increased risk to people's safety. Relatives of people and members of staff gave us their views on staffing levels. One relative, who was generally happy with the service, said, "I think they could do with more staff." A member of staff told us, "I think we need more staff… I think we really need to have more for the number of the residents, more care assistants and more seniors."

The registered manager told us they did not alter the number of staff if people using the service changed. We viewed the service dependency assessment. This showed that approximately ten people using the service needed two carers to assist them and 20 people were deemed as high risk. Staff rotas over the past four weeks suggested that the number of staff remained constant.

At lunchtime on both days, we saw people left unattended for periods of time whilst staff went to collect meals from the kitchen. We saw people getting up from the table and start walking around. Hot meals brought through from the kitchen were not always served promptly because staff were preoccupied with other tasks. As a result, people's food was left standing to go cold. We saw that one person took their plate of food to reheat it in the microwave in the open kitchen area. They were not supervised as staff were too busy. The person had to reach up to use the microwave in the open kitchen and then lift the plate of hot food down. There was no risk assessment in place for this activity and the person was at risk of harm from handling a plate that was too hot.

We reviewed the details of staff files for three of care staff. These demonstrated that the correct process was not always followed to help ensure that only staff with suitable background, experience and skills were employed. The service undertook appropriate checks with the Disclosure and Barring Service (DBS) prior to the offer of a position. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. The files demonstrated that the manager had interviewed the applicant, reviewed their identity, employment history and received two references. One of the files contained an inappropriate reference and an unconditional offer of employment letter was dated before receipt of a clear DBS check. It was not clear when the letter was actually sent.

People said they felt safe. They told us that staff responded quickly to call bells and checked on them regularly. They also felt they were well supported with mobility aids and pressure mats. We saw that the service kept details of people's personal evacuation plans near the front door.

Staff we spoke with had all received training in safeguarding. They understood safeguarding and what constituted abuse. Staff knew how to report any safeguarding concerns and had access to the contact

details for the relevant agencies displayed in the staff room. Staff also demonstrated awareness of the whistleblowing procedure and said they would have no hesitation in reporting concerns to agencies outside of the service if needed. All members of staff spoken with said that they felt confident the manager would appropriately act on any concerns they raised.

The registered manager informed us that safeguarding notes would be in people's files. However, there was no information in the file of the person involved in the safeguarding referral. There was no evidence that staff had undertaken a review of the person's risk to others or taken any action to avoid a reoccurrence of the event. The registered manager showed us their 'Safeguarding' folder which did not contain details of this referral.

The premises smelt and looked clean and we saw evidence of completed cleaning schedules. People and their relatives told us that the cleaners worked hard to keep the house constantly clean. Staff we spoke to understood how to control the spread of infection when they cared for people.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection in February 2018 identified that staff had a poor understanding of the Mental Capacity Act (MCA) 2005. The service did not comply with the provisions of the legislation and as a result people's rights were not protected. At this inspection we found no improvements in this area. During our last inspection we also found there were shortfalls in the training staff received and this continued to be the case. This key question therefore remains as 'requires improvement'.

The MCA provides a legal framework for making 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 decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The authorisation procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). The MCA DoLS require providers to submit applications to a supervisory body for authority to do so.

Care files did not show that people's capacity had been assessed. We could not tell if decisions relating to people's care had been reached by appropriate persons and professionals. We were unable to determine if the least restrictive care option had been chosen and if it was in the person's best interests. Information pertaining to the DoLS applications was also poorly recorded and monitored. The registered manager informed us that DoLS were either in place or had been applied for most of the people living in the home.

For people lacking capacity to take their medicines, they were being given covertly. In some cases, we found that the GP had been contacted and had given their agreement for medicines to be administered in this way. However, there was no mental capacity assessment or best interest's decision to demonstrate that the principles of the MCA had been followed.

We were informed that this was an area that had been planned for development. The action plan drawn up following our February 2018 inspection confirmed that training would be arranged. Records showed the registered manager and deputy received training in March and August 2018. It was disappointing, therefore, that this had not led to some improvement. Seven care assistants remained untrained.

The registered manager and deputy manager did not demonstrate a good understanding of the MCA or DoLS. There was no clear indication of when people's care files would be reviewed to ensure their rights under the MCA were being protected.

The care staff we spoke with showed some awareness of the importance of consent and the importance of offering people choice. When asked if they assist people to make their own decisions, a care assistant told us, "If they cannot for themselves, then we have to do it for them, but we do ask if they can make a decision." Another staff member told us "I seek consent every time because it is important to ask." Care staff were not

able to explain what mental capacity meant.

The above findings meant that the provider continued to be in breach of regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

We reviewed the training records of all the staff employed by Shiels Court. We noted in our inspection of February 2018 that training was not provided to cater for the needs of the people who might be cared for by service. This continued to be the case. However, dementia training had been offered since the previous inspection although one senior and five care assistants remained untrained.

There were many other gaps on the training records we viewed. For example, two senior members of care staff, three care assistants and five non-care members of staff had not received safeguarding training. Some care assistants were working without training in key areas of care. This included pressure care management, nutrition and hydration, continence management and behaviours that challenge. One of the cooks had not undertaken training in areas including food hygiene, infection control and health and safety. The registered manager was not trained in first aid, infection control, health and safety, GDPR and food hygiene.

A member of staff commented on the lack of training provided to use their electronic care system hand-held devices. They said this prevented them from recording accidents and incidents correctly.

There was some evidence that training received had not been effective. For example, a file containing 'discussions and verbal warnings' revealed a discussion between a senior and a care assistant about their poor moving and handling practice. This occurred nine days after the care assistant had completed their moving and handling training. The staff members we spoke with had undertaken training on the MCA but their understanding of this piece of legislation was very limited.

These findings showed a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed supervision, appraisal and performance records. Some care assistants had been supervised and or appraised by a senior. Some care staff were competence assessed in their delivery of care. It was not clear how regularly these activities took place.

People were supported to maintain their nutritional and hydration needs although this aspect of their care could be improved. We twice observed people having their lunch. We saw that staffing levels were not sufficient given the duties they were required to undertake and people's level of need. Staff had to collect people's meals from the kitchen, support people with their eating and make and serve cups of tea. They were also required to serve and assist people who had stayed in their bedrooms to eat and drink.

We saw a lot of food left uneaten and returned on the serving trolley. Staff were too busy to engage with people and encourage them to focus on their eating. Food was at risk of going cold before being served. One person who needed support to eat had their meal left on a side table covered but unheated until a carer could assist them. They were given their meal 25 minutes after the food had been brought out of the kitchen.

Lunch was due to be served at 1pm although we observed that people were brought their meals from approximately 12. 45 pm to approximately 2 pm. People were sitting at tables waiting for their meals for about an hour in some cases. We saw one relative assisting their relatives to eat, and helping other people sitting at the table. This was due to the lack of staff present. They told us, "It is my choice to help [family

members] with their meals. I like to do it. I will also help others to have a drink, it frees up the staff to help others then."

There was a mixed understanding of how people were offered choices of meal. The registered manager and a member of care staff told us people would be offered a plate of food and if they didn't want it, the chef would cook them something else. However, the chef told us that they were given a list of how many different meals to make each day. They said this was based on what people had chosen. There were no menus on display. Two people told us they didn't have a choice of meals but one person said they did. A relative told us people would always be given an alternative meal if they wished. People told us and we saw that a variety of drinks were constantly available.

The chef told us they used a four-week rolling menu which was based on people's preferences. The chef was aware of individual's dietary needs and preferences and had clear information available to ensure the correct type of meal was always provided. They were enthusiastic about meeting individual likes and dislikes and keen to introduce a new menu based on nutritional, home-cooked dishes. Staff regularly monitored people's weight and fluid intake. The records of one person, who needed encouragement to eat, showed their weight had remained constant.

Some care files demonstrated that people's care needs had been holistically assessed and contained information about their physical, mental and social needs. For example, they contained a 'This is Me' document which gave information about the person's life history. The registered manager told us that they were in the processing of ensuring this document was completed for all those people living with dementia.

One person's care file contained a transfer letter in the event of hospitalisation. We were also told that 'hospital passports' were used if a person need to be transferred. These were designed to contain key information relating to the person's health and care needs. Certain identified risks information about how to reduce the risks were missing from these packs though. The registered manager had started to complete these at the time of the inspection.

During the inspection, a doctor and a paramedic practitioner from the local surgery visited the service. The paramedic practitioner visited regularly to assess people and undertake medication reviews. The paramedic practitioner told us, "I think [registered manager] does really well at managing people. They are very on the ball and quick to contact us if someone has an urgent need." People and relatives told us that health professionals were called quickly when needed and that chiropodists and opticians visited the home.

The home was light, airy and spacious. People said they felt warm and comfortable. There were three large lounges and a very large dining and music area. People could therefore spend time in a variety of locations, as well as their bedrooms. If there was music in one room, people could find quiet spaces elsewhere.

Since the previous inspection there had been changes made to the interior layout and use of the space. One relative told us, "They always seem to be decorating and improving things here." The registered manager told us that further improvements to the home were scheduled. It was acknowledged that the decoration of the one functional bathroom and the one shower room was a priority.

The provider had already replaced about half of the flooring. Dementia-friendly signage was on toilet doors. We were told that signage of this type would be used elsewhere too. A unisex toilet still had the sign saying 'gentleman' on it. The corridors to people's rooms were decorated with interesting outdoor features. The use of brick wall wallpaper in one corridor gave the impression that people's bedroom doors were front doors.

Good

Is the service caring?

Our findings

Following our last inspection of this area in February 2018, we rated 'caring' as requires improvement. This was due to people having poor experiences of care and variable levels of staff interaction. At this inspection, we observed that improvements have been made and we have rated 'caring' as good.

Relatives told us they were happy with the care their family members received. People felt that the staff were kind and caring. One relative told us, "The staff are so good and can't do enough for you" and another said, "I think the general care here is very good, [family member] is taken care of very well." People were generally happy with the way they were looked after. One person told us, "The staff take their time with you and are always willing to help you." Another person said, "I like living here, the staff are kind."

The people we spoke with wore clean glasses and their hair looked nice. Some people had their nails painted by the staff and they appreciated the visiting hairdresser. We heard positive comments from the relatives of two people about the efforts staff took to support their relative's appearances. One relative told us." The staff keep [family member] so clean. They take them to have their hair done which they love." Another relative told us," The staff will go in and paint [family member]'s nails which they like."

We observed some caring interactions between care staff and people living in the home. For example, one care assistant helped a person to drink through a straw with encouragement and reassurance. They knew that with other people they could take a more humorous approach though and changed their behaviour accordingly. For example, they jokingly asked another person if they would like red wine, although it was really blackcurrant squash. People at the table laughed and clearly understood and enjoyed the conversation. A relative told us, "The staff have a laugh and a joke with [relative]. It really helps."

A family member told us that care assistants showed tenderness to people. They said," I have seen carers go up to people and give them a cuddle and a kiss on the cheek." A person told us, "Oh the staff are wonderful. They are my family."

The care plans we reviewed contained information which supported person-centred care delivery. A member of staff we spoke with showed a good understanding of a person's personal history. They explained how this helped them to support a person whose behaviour was sometimes difficult to predict. They were also able to tell us that one person particularly liked to have their hair permed regularly. This was in accordance with the person's care plan.

The support provided to people at lunchtime was task as opposed to person-focused. Terms of endearment were used throughout people's meal-time but there was no conversation. People were just asked to open their mouths or eat their food. Staff did not have enough time to interact with them. A member of care staff told us, "Some days there is not enough time, but you do the best you can."

However, two people told us that when provided with care, they were not rushed. One person told us, "The staff take their time with you and are always willing to help you." Another person told us that staff did not

rush them, which they liked. We observed two carers supporting a person to move with the use of a hoist, so they could sit at a table. They explained what they were doing and took their time with the resident.

The registered manager was keen to support people's right to choose and to promote their independence. As an example, a person's care plan stated, 'Encourage [person] to pick their clothing for the day once they seem calm'. People and relatives reported that people were provided with choice in respect of their care. One person told us, "I go to bed about 8.30pm. They don't mind when you go." Another person said, "I can have a bath or shower when I want." People were able to eat where they preferred. They could also get up when they wished. We observed people being offered a choice of drinks and activities. People were free to wander around the home and sit wherever they wanted to. The registered manager told us that where possible, they accommodated people according to their preferences. The home had both single and double rooms and people moved rooms if they wanted to. People were able to go outside in an enclosed area to smoke. There were restrictions on people leaving the home, for their own safety. However, they were otherwise free to decide how and where they spent their time during the day. One care assistant told us, "We try to encourage people to be as independent as possible. You've got to keep them able where possible."

Staff were aware of people's mechanisms for communicating. One person did not speak but a care assistant explained how they interpreted their signs and gestures. We heard how the service supported people to have their eyes tested and encouraged people to wear glasses when needed. This was important as it aided their ability to engage and communicate effectively.

People and their relatives were involved in making decisions about their care. One relative told us, "I have been involved in planning what help [person] needs. I feel fully involved"." Another relative told us," The manager came and did an assessment before they were admitted. My [family] deals with most things and they were involved in discussing their care plan."

The registered manager told us that information about an advocacy service was available in the hallway. This service would be used if a person did not have a relative or friend to assist them.
People told us that staff knocked on doors before entering and this was observed during the inspection. People also felt that staff respected their privacy and dignity. They told us that staff closed doors and curtains when delivering personal care and ensured they were covered wherever possible. A care assistant showed an awareness of the need to treat confidential information people told them carefully. They told us, "If a person is a giving me information I should not be telling other people like confidential matter, I will only tell the manager." We observed that care files were kept in the manager's office and the door automatically locked upon closing. Care staff told us that their hand-held devices were password protected.

We observed care assistants providing support to people at lunchtime which was not particularly dignified. For example, one care assistant assisted two people who were unable to communicate and seated in large mobility chairs. The care assistant spilt the pureed food they fed to the first person down their neck. They then spilt thickened drink down the front of the second person they assisted. We also heard a care assistant saying, 'good girl' to people and 'are you alright sweetheart?'. Whilst these comments might have been well-intended, they could have perceived as being patronising.

People and relatives said that people's laundry would often go missing. The registered manager explained the various measures they had tried to resolve the issue and stated they planned to make further improvements to the laundry process.

Requires Improvement

Is the service responsive?

Our findings

Following our last inspection of this area in February 2018, we rated responsive as 'good'. At this inspection we have rated responsive as 'requires improvement'. This is because care plans were not regularly reviewed or updated and improvements were required to end of life care planning.

At our previous inspection, we found that information on people's care needs was not easily found in all care files. However, there was evidence that the registered manager and staff knew people's needs well and could explain how they were met. Care records were being transferred on to a new electronic care planning system.

During this inspection, we found the same situation. Once fully operational, the electronic system should enable care staff to access people's care plans, risk assessments, monitor their support needs and record all care interventions. Whilst the system contained many positive sounding features, it could only be effective upon staff fully understood how to use it.

We looked at paper care records. We found that people's records were not consistently maintained. However, we were again told that their needs were being met. This was due to staff knowledge of the people they cared for.

Two of the care files we looked at were incomplete. In one person's care file, a fall was recorded but it was not clear that the person's falls risk assessment had been reviewed. Another person's care file contained neither a record of their recent falls nor a falls risk assessment. However, the care files did contain person-centred information and recently reviewed care plans. There were clear instructions on how to meet dietary, nutritional and medication needs. People's emotional and social needs were also addressed. For example, one person's care records said, '[person] enjoys kittens and rabbits. They help calm them down. It is important to encourage [person] with these interactions'. The home had two rabbits living in hutches outside and two cats in the home. Whilst not everyone we spoke to was uplifted by the animals, we observed a few people stroking the cats during the day. One relative told us, "[Relative] loves to see the animals and it cheers them up."

We were told that staff would not refer to people's full care records but another set of documents. These were referred to by the registered manager as 'passports'. They did not give a full overview of a person's individual risk factors. The care assistants we spoke with said they relied on a combination of the 'passports' and the electronic devices. However, one of the care assistants did not know how to use the electronic device fully.
Relatives felt that staff knew people well. We observed the deputy manager talking to families throughout the day. One relative told us," Staff try to get to know everyone. They ask questions about people's families and their likes and dislikes. They also want to know what the residents used to do." Another relative told us," The staff seem to know the residents well." This sentiment was echoed by the healthcare professional we spoke with. Staff members we spoke with knew about people's needs. For example, one care assistant was able to clearly tell us how to manage a person's dietary and behavioural needs. We heard examples of

how staff responded well to people's needs and produced good outcomes. For example, one relative told us, "[Person] can get aggressive but the staff use banter to calm them down and it works really well."

People told us that visitors could come whenever they wish and there were no restrictions. Relatives confirmed this. One family member told us," The staff have told me I can come and visit whenever I want. I can stay all day if I want, they have offered me meals and you can make a drink when you want. They have also said that I can stay the night or if I am worried during the night I can come and they will let me in." Another relative told us, "The staff make you feel really welcome. They offer you a drink as soon as you arrive."

We were told that two members of staff organised activities. We could not see any notice of activities that were due to take place. A newsletter was on display and this detailed things that happened in the previous month. We saw that one table was set up with different board games and another had paper and colouring pencils. When we went back later these had not been used. The activities person was sitting at a table with several people. They were reminiscing and looking at a newspaper.

One person told us, "I think there are plenty of things to do, they keep you busy. I have my nails done and the hairdresser comes in regularly, I always enjoy that. We have a card school. We have been on trips out." A relative told us, "They had a 1940s afternoon which was lovely. At Christmas a choir came in. They took [person] to the Sea Life Centre at Great Yarmouth. I was amazed because I couldn't get them out of the house."

The registered manager told us that the local Church did a Sunday service in the home once a month and provided a carol service. They said that people had attended Church if they wanted to for Armistice Day and at Easter.

The people and relatives we spoke with said they had felt no need to raise any complaints or concerns. They said that they would speak to the management or senior staff if they did. The service held a complaints log which contained one complaint. This had been dealt with appropriately.

People's wishes regarding resuscitation in the event of cardiac arrest were evident in some care files. However, the files we reviewed did not contain any other paperwork relating to end of life care wishes and preferences. Staff would not know how a person wished to spend their last days or how they could provide comfort, such as playing their music of choice. There was no indication whether the person had any spiritual, religious or cultural wishes relating to the end of their life. This demonstrated a lack of personalised care planning.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in February 2018 we identified that improvements in the governance of the service were needed. At this inspection we continued to find shortfalls in this area. Audits of the premises, equipment, care files and medicines were not routinely taking place. Where audits were undertaken, issues identified were not always being addressed. The governance systems did not drive improvement. The management of care records was also below the expected standard. The provider and registered manager did not meet their regulatory and legal obligations and there continued to be shortfalls in the management of the service.

This key question was rated as 'requires improvement' in the two previous CQC inspections in 2018 and 2016. In 2015 it was rated as 'inadequate'. After the last inspection, the provider was required to send the CQC an action plan to outline their planned improvements. They did not do this and therefore failed to comply with regulatory requirements. The registered manager was unaware that the service was in breach of two regulations. This demonstrated that both provider and registered manager had a poor understanding of their regulatory responsibilities.

We identified an accident in December 2018 which led to a person sustaining a serious injury. The provider should have notified the CQC of this incident but did not. The provider also failed to notify the CQC of a safeguarding referral made in June 2018.

We reviewed incomplete records relating to premises audits and these did not ensure good and safe care delivery. For example, records showed that housekeepers checked two rooms in October 2018. Issues such as 'hot tap dripping slightly' and 'needs toilet roll holder' were identified. In both cases, the outcome was recorded as 'maintenance to advise'. We looked in one of these rooms. It had been partly redecorated but the tap and toilet roll holder issues had still not been repaired. The records for monthly checks on other rooms did not provide clear information about the issues identified, nor whether they had been rectified. Kitchen audits were undertaken monthly but records showed that actions were routinely carried over to the next month. For example, new first aid kits had been carried over as a 'to do' action every month since July 2018. There were no care plan, call bell, cleaning or equipment audits. Infection control audits had, however, taken place monthly from July.

Record-keeping in relation to medication, care plans, safeguarding, consent, risk assessments and auditing was below the expected standard. Some of the documents were out of date and contained inaccurate information. One record was hand-written on a crumpled piece of paper. There was missing documentation in care plans relating to risk assessments, consent and end of life care wishes. The paper records needed to be complete and up to date, particularly as some staff still referred to them. The transfer of people's records to the electronic care system was still ongoing, having started prior to the previous inspection.

The poor governance and record-keeping constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they had regular contact with the provider, who visited the home once or twice weekly. The manager said they felt supported and had a good working relationship. We were told there was a commitment to improving the premises and the quality of care delivery. An action plan for 2018 and 2019 indicated that refurbishments and some changes to the layout of the home and gardens were intended. Some of the plans had been actioned. The registered manager told us they were also committed to improving service delivery, service management and staff development. It was not clear how long it would take to achieve the desired progress as the action plan lacked detail. The registered manager said that discussions with the provider had led to a change in staffing structure. The aim of this was to enable service improvements to take place but it was too early to see the impact of this. It was difficult to see how the planned development could take place with the current staffing levels.

We heard positive comments about the management of the service though. A visiting health care professional told us, "[registered manager] is a very good manager, very organised, they know their residents very well, they have worked in care a long while." People and relatives told us they felt the manager and deputy were approachable, friendly and helpful. They were confident in their ability to resolve any issues. One family member told us, "[registered manager] had a chat with me today and always seems on top of things." Another relative told us the manager was always available. They said, "I have seen the manager regularly, they always speak and always let us know if anything has happened with [relative]." Two relatives praised the manager for their openness. One of them told us, "I came to look round unannounced. They showed me round immediately and didn't try to hide anything. I was really impressed with that." Relatives all said they would recommend the home.

We saw minutes of staff meetings but these did not occur regularly. The registered manager said they had an 'open door policy' and undertook regular walkarounds. They said they sought to motivate staff by taking note of their suggestions, praising good performance, and supporting staff development. A member of staff told us, "[registered manager] values opinions, they are good, they always support the staff." Another staff member told us, "I like working here, you can go into the office and management will help. [registered manager] is there if you need them."

The service did not hold any resident or relative meetings. One relative told us they were updated of what was happening in the home by a newsletter. The service had started to gather feedback from relatives and we saw some returned questionnaires from a December 2018 survey. The registered manager acknowledged that they needed to seek feedback from people using the service, staff and health care professionals. They indicated that this was planned to take place in 2019.

The manager responded positively to a recent inspection by the local authority by addressing some of the issues identified. In response to concerns we raised about the tap hot water temperatures and exposed hot pipes, the registered manager took prompt action.

There was some evidence that the service worked with external agencies to support the delivery of good care. A strong relationship existed between the home and the local GP surgery. The registered manager told us they had started to attend the North-East Norfolk Registered Managers Group. They also received bulletins from the Norfolk and Suffolk Care Group.

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 11 HSCA RA Regulations 2014 Need for consent People were not protected against the risks associated with giving their consent to care, support and where required treatment. This was because the provider was not acting in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm from environmental hazards, irregular reviews of their personal risk assessments, poor medicine management, incomplete recording of accidents and incidents and insufficient staffing at lunchtime. Regulation 12 (1) and (2) a, b, c and g

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider took insufficient actions to mitigate the risk of people experiencing harm from scalding. Auditing was not routinely undertaken or effective, there was a lack of improvement made since the previous inspection in respect of Regulations 11 and 18 and there was a failure to comply with

	regulatory requirements after the last inspection. Regulation 17 (1) and (2) a, b, and c

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Some staff were inadequately trained and competence assessed to ensure safe care was provided. Regulation 18 (1) and (2) a