Solent View Care Home Limited

Solent View Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Solent View 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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home accommodates up to 19 people and at the time of our inspection 17 people were living at the home, two of whom were in a shared room. The accommodation was based on two floors connected by a passenger lift. The kitchen, sluice room and staff offices were based on the third floor of the home.

This inspection took place on 26 and 27 February 2018 and was unannounced.

There was a registered manager in post at the service. 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 and associated Regulations about how the service is run.

We identified widespread and systemic failings during this inspection. The provider's governance arrangements had not been effective in ensuring the fundamental standards of safety and quality were met. Appropriate quality assurance systems were not in place, there was a lack of resilience in the management structure and an accessible complaints procedure was not in place.

Staff who administered medicines were not always trained and people did not always receive their medicines as prescribed. Medicines were not always stored safely or recorded in accordance with best practice guidance.

Areas of the home were not clean, including the sluice room and a bathroom. Infection control arrangements were not adequate to prevent the risk of cross contamination. The laundry room was not fit for purpose. Legionella risk assessments and infection control audits had not been completed.

Individual and environmental risks to people were not always managed effectively, including risks posed by choking and pressure injuries. Not all staff had completed fire safety training, including senior staff who were expected to take charge in an emergency.

Action had been taken to reduce the risk of people falling; however, records of people's falls were not completed accurately to allow the provider to identify patterns or trends.

Safe recruitment procedures were not always followed to help ensure only suitable staff were employed. Not all staff had completed essential training to undertake their roles.

People had mixed views about the food and choices were not offered in an effective way for people living

with dementia. We could not be assured that people's dietary and hydration needs were met consistently.

Staff followed legislation designed to protect people's rights. However, assessments of people's ability to make specific decisions had not always been completed.

Some adaptations had been made to the home to make it supportive of the people who lived there, but the home was not accessible to people who used wheelchairs and some people reported excessive levels of noise that upset them.

Some staff showed a lack of consideration for people's dignity, for example in the way they cared for their clothes and stored continence aids in their rooms.

Most people were complimentary about the attitude of staff, but some described them as "off-hand" or "unhelpful" at times. We observed some positive interactions between people and staff, but also heard inappropriate language being used by staff who were not always discreet.

Staff demonstrated a good understanding of people's individual needs, although records of the care they provided did not confirm that the needs of four people being cared for in bed had been met.

Staff described how they supported people at the end of their lives, but most had not completed end of life training and people's end of life wishes had not been recorded in their care plans.

The provider sought and acted on feedback from people, but action taken was not always effective. There was not a policy in place to ensure staff acted in an open and transparent way when people came to harm.

Staff completed pre-admission assessments before people moved to the home and supported people to access healthcare services. They understood their safeguarding responsibilities and there were enough staff deployed to meet people's needs.

Staff promoted independence and usually involved people in discussions about their care. People had access to a range of activities including one-to-one conversations with an activities coordinator.

Staff were happy working at the home and felt supported in their roles by the registered manager.

We identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about the commission's regulatory response to the breaches will be added to the report after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another

inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely. Not all staff had received appropriate training and people did not always receive their medicines as prescribed.

Infection control procedures were not in place to protect people from the risk of cross infection. Some areas of the home were not clean and the laundry room was not fit for purpose.

Individual and environmental risks to people were not always managed effectively. Some senior staff who took charge of the shift had not completed fire safety training.

Recruitment procedures were not followed to help ensure only suitable staff were employed.

Staff understood their safeguarding responsibilities, although some had not completed or refreshed their safeguarding training. There were enough staff deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had completed training that was essential to their role.

People had mixed views about the food and some people's dietary needs were not met in a personalised way.

Staff usually followed legislation designed to protect people's rights. However, capacity assessments had not been completed for all relevant decisions relating to people's care.

Some adaptations had been made to the environment to make it supportive for people, although the home was not accessible to wheelchair users and some people reported unacceptable levels of noise.

Senior staff completed pre-admission assessments before people moved to the home. People were supported to access healthcare services when needed and there were procedures in place to help ensure that people received consistent support when they moved between services.

Staff felt supported in their role by the registered manager and made appropriate use of technology to support people.

Is the service caring?

Requires Improvement

We received mixed views from people about the manner and attitude of the staff. Some staff used inappropriate language when talking about people, although other staff interacted positively with people.

Some staff showed a lack of consideration for people's dignity.

People told us staff respected their privacy when providing person care. Staff promoted independence and explored people's cultural and diversity needs.

People were involved in discussing and making decisions about the care and support they received, although their views were not always recorded.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider was unable to confirm that the needs of people who were cared for in bed were being met. Records of care provided to people were not adequate.

An effective complaints procedure was not in place.

Staff supported people at the end of their lives to have a comfortable, dignified and pain-free death. However, most had not received end of life training and people's care plans lacked information about their end of life wishes.

People had access to a limited range of activities including one-to-one conversations with an activities coordinator.

Is the service well-led?

Inadequate

The service was not well-led.

Governance arrangements were not effective in meeting

fundamental standards of quality and safety.

The provider did not operate an effective quality assurance process to assess, monitor and improve the service.

The provider did not have a policy to ensure staff acted in an open way when people came to harm and had not provided written information to people when required.

The provider sought and acted on feedback from people, but this was not always effective.

Staff were happy working at the home, but there was a lack of organisation in the way they were organised.

Solent View Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted, in part, by safeguarding concerns that had been shared with us by the local authority.

This inspection took place on 26 and 27 February 2018 and was unannounced. It was completed by three inspectors on 26 February 2018 and one inspector on 27 February 2018.

Before the inspection we reviewed all information we had received about the service, including the provider's action plan for improvement and notifications. Notifications are information about specific important events the service is legally required to send to us.

We spoke with eight people who use the service and two family members. We spent time observing the way staff interacted with people who use the service. We spoke with the registered manager, the deputy head of care, six care staff, a maintenance worker, a cook, a cleaner and an activity coordinator. We spoke with a GP who had regular contact with the service. Following the inspection, we received feedback from three health or social care professionals who had contact with the service.

We looked at care plans and associated records for six people and records relating to the management of the service, including: duty rosters, staff recruitment files, staff training records, accident and incident records, maintenance records and quality assurance records.

Inadequate

Is the service safe?

Our findings

Care and support were not always provided in a safe way. We identified significant concerns relating to the management of medicines, infection control and risk management arrangements.

Not all staff who administered medicines were suitably trained. A senior staff member who administered medicines during the day had not completed medicines administration training since July 2016, when they failed the knowledge check at the end of the course. Two senior staff who took charge of the night shifts had not completed any medicine administration training. This meant people who needed as required (PRN) medicines, such as pain relief, at night could not receive them. Staff told us their competence to administer medicines was checked regularly by the head of care or deputy head of care. However, these checks were not recorded and the provider did not follow clear and consistent criteria when conducting these checks. The provider was unable to confirm that staff who administered medicines were suitably trained and competent.

People did not always receive their medicines as prescribed. When people were asleep during the medicines round, staff recorded this on the medication administration record (MAR) but, in most cases, did not return to offer the medicines again when the person awoke. This included an antibiotic for one person who had a urine infection, who was asleep during the lunchtime medicines round on the first day of our inspection.

One person was prescribed medicines on a PRN basis, but there was no information available to help staff know when to give these. Another person was prescribed Warfarin, a blood thinning medicine. This required regular blood tests so the dose could be adjusted. The results of the person's previous blood test, 12 days before the inspection, had not been passed to the home and staff had not followed this up. On checking with the GP, it transpired that the person's dose had not changed, but staff were not aware of this. People taking Warfarin are at increased risk of bleeding if they sustain an injury; however, assessments of this risk, together with actions to reduce the risk had not been completed. The care plan for another person noted that they were allergic to two types of medicine, but this information was not included on their MAR chart. As care plans were not routinely checked during the medicines round, this posed a risk that the person might receive medicines to which they were allergic.

Most medicines were stored securely in locked trolleys or cabinets. However, we found medicines for a person who looked after and administered their own medicines were not kept securely. We saw five of their medicines, including ibuprofen tablets and paracetamol tablets, had been left on top of a cabinet in their bedroom. These were in full view from the corridor and could have been accessed by people not prescribed them, including people living with dementia. This put them at risk of harm. A risk assessment stated these medicines should have been kept in a locked drawer, but this was not being used.

There was no system in place to ensure medicines which needed a specific time gap between administrations were always administered safely. For example, paracetamol was being administered four times a day to some people, but the actual time of administration during the course of a medicines round was not recorded. Therefore, we could not be assured that administrations were at least four hours apart.

Staff did not monitor the storage temperatures of medicines in line with best practice guidance. Medicines that needed to be stored at cool temperatures were kept in a medicines fridge. Staff monitored the temperature of the fridge occasionally, but did not do this regularly and did not monitor the minimum or maximum temperature of the fridge in accordance with best practice. Also, staff only monitored the room temperature where one of the two medicine trolleys was kept, so were unable to confirm that medicines in the second trolley were stored at a safe temperature. In addition, they had not taken action when the temperature of the first trolley had exceeded the recommended 25 degrees Celsius. This posed a risk that the medicines might not have been fully effective when used.

Topical creams were not managed effectively. Staff did not record when and where they applied creams to people. In a shared room, we found creams that did not have the name of the person they had been prescribed for. In another person's room, we found a tub of cream that had been prescribed for a different person. Topical creams have a limited shelf life once opened, yet there was no system in place to monitor this to help ensure they were not used beyond their safe 'use by' date.

Guidance issued by the National Institute for Health and Clinical Excellence (NICE) recommends that hand written entries on MAR charts are checked by a second member of staff to ensure they have been accurately transcribed, but we found this was not always done. Entries on other MAR charts had been made against the wrong date. For example, the MAR charts for the whole week of the inspection had already been completed in error.

Suitable infection control procedures were not in place and some areas of the home were not clean or hygienic. On the first day of the inspection, the sluice room was not clean. Dishwasher salt and liquid were stored immediately below the sluice where commode pots were emptied; this created a risk of cross infection by splashing. Immediately outside the sluice room was an opened bag of potatoes and an open net of onions, posing a further risk of cross infection. The sluice room did not have a hand wash sink, so staff would have to walk past the kitchen to a staff bathroom to wash their hands after handling used commode pots, which created further risks.

The first floor bathroom was not clean. Under the bath was an old, used bar of soap and an old flannel. The toilet frame was rusty where it met the floor, creating a bacteria trap. The chair on the bath hoist was not clean and there was a thick layer of grime on the restraining straps. The pedal bin was overflowing with used tissues and we saw other used tissues and used aprons pushed down the side of the sink.

In a room shared by two people, a single cabinet was used to store all their toiletries. In the cabinet, we found a brush with a third person's name on it and three combs that were all dirty. There was a named pot with one toothbrush in it, together with three other toothbrushes (none named), one of which was laid on a dirty comb. The lack of clarity as to which person used which toiletries posed a risk they could be shared and cause cross infection.

The laundry room was not fit for purpose. It was based in a shed in the garden and was also used to store tools, paints etc. There was no process in place to prevent cross contamination between dirty items entering the laundry and clean items leaving the laundry. Red, soluble bags containing potentially infectious linen had been placed on the floor of the laundry, alongside baskets containing other laundry. There were no records to show when the laundry room had last been cleaned. It was not a clean or hygienic environment in which to launder people's clothes. The sink was stained black with mould in places and had loose dirt in the bottom. It was the only hand washing facility available, but there was no liquid soap of paper towels for staff to use. Staff told us they used a sink in main building after handling soiled linen, but this could only be accessed by passing through a kitchenette used to prepare people's drinks.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. The code of practice requires providers to complete an annual statement detailing what policies and infection control risk assessments were in place, and any staff training or outbreaks of infection that had occurred. It also requires providers to complete an audit programme to ensure policies had been implemented. The provider had not completed an annual statement or any infection control audits. The code of practice further requires providers to have policies to manage the risk of Legionella. The registered manager told us they did not have a Legionella policy and had not assessed the risks posed by Legionella. The provider could not demonstrate that the risks of people acquiring an infection had been identified, assessed and mitigated effectively.

Individual risks to people were not always managed effectively. Some people, who had been assessed as at risk of choking, had been prescribed a thickening agent to add to their drinks. When we spoke with staff, we found most did not know how to thicken drinks to an appropriate consistency. When we looked at one person's drinks, we found one was too thick and the other was too runny. The runny drink would not have been effective in reducing the risk of choking. The thickening agent can be dangerous if eaten on its own, but not all staff were aware of this and we found two tins of it in a person's bedroom. The person's room was accessible to other people, including people living with dementia, who might not be aware of the risks.

People were not always protected from the risk of pressure injuries. Three people were being cared for in bed and required support to reposition regularly. Although staff told us they did this, they did not keep records to confirm this or to show which position the person had moved to. These are necessary to help ensure the person is not continually placed into the same position. Staff told us they used slide sheets to move people up the bed, but on the first day of the inspection these were not available for two people. If staff move people without using appropriate equipment, it poses a risk of bruising or skin tears to the person and a risk of upper limb injuries to the staff concerned.

Some people who spent a lot of time sat in a chair had been given special pressure relieving cushions to use. However, we saw one person had not been supported to use their cushion, which put them at increased risk of developing pressure injuries. However, other people were being cared for on pressure-relieving mattresses and an appropriate system was in place to ensure these were used and that they remained at the right setting.

Some risks posed by the environment were not managed effectively. For example, we identified a hot radiator in one person's room that was not protected by a cover. This posed a risk that the person using the room, whose mobility was very poor, might fall against it and sustain burns. We discussed this with the registered manager, who arranged for the radiator to be replaced.

Staff were required to complete fire safety training every year. However, some staff had not completed this training and other staff had failed the knowledge check at the end of the course but had not re-taken it. This included two staff members who took charge of the shift on nights and one staff member who took charge of the shift during the day. Therefore, we could not be assured that all staff would know what action to take in the event of a fire or that the person in charge could take effective control in an emergency.

The registered manager told us they monitored the incidence of falls by viewing logs of falls in people's care plans. However, we found the fall logs were not always accurate or up to date, so could not be relied on to identify patterns or trends.

The failure to ensure that medicines were managed in a safe way, that the risk of infection was managed

appropriately and that risks to the health and safety of people were assessed and mitigated, were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other environmental risks were managed appropriately and procedures were in place to deal with foreseeable emergencies. These included personal emergency evacuation plans, detailing the support each person would need if the building needed to be evacuated. Reciprocal arrangements had also been made for a neighbouring home to act as a place of shelter in an emergency. Gas and electrical equipment was checked and serviced regularly. A risk assessment had been completed for a hot water urn in a kitchenette that was accessible to people and a device had been fitted to prevent it being used without staff support.

Action had been taken to reduce the risk of people falling. One person told us that when they used the shower staff stayed with them if they felt "unsteady". They added, "It's for safety and [my] peace of mind." The provider had recently purchased pressure alert mats and chair alarms to alert staff when people at risk of falling moved to unsafe positions. A GP who had regular contact with the service told us staff were "more aware of [falls] risks now".

Appropriate recruitment procedures were in place; however, these were not always followed to help ensure only suitable staff were employed. We found references for two staff members had not been obtained before they started work at the home. For example, one staff member started work six weeks before their references were received. Assessments of the risks posed by the lack of references had not been completed and measures such as enhanced supervision had not been put in place to reduce the risk. The provider had conducted checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions by disclosing any previous convictions held by the applicant. However, arrangements were not in place to assess the risks posed by staff members who had previous convictions and to identify any additional measures needed to protect people.

The failure to operate effective recruitment procedures was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, people told us they felt safe at Solent View. One person said, they felt "safe and respected" by staff. Another person told us, "I feel very safe and very secure. I get treated really well." Staff understood their safeguarding responsibilities and those we spoke with knew how to identify, prevent and report abuse. However, nine staff members had not completed or refreshed their safeguarding training in line with the provider's policy, so we could not be assured that all staff had the necessary knowledge. Staff were confident the registered manager would respond to any concerns they raised and most knew how to contact external agencies for support if needed. One staff member told us, "They [the people living at Solent View] are vulnerable and we have a great responsibility for caring for them."

There were enough staff deployed to respond to people's needs. The registered manager told us staffing levels were based on people's needs, together with feedback from people and staff. They had recently increased staffing levels, to three care staff throughout the day, having identified that people's needs had increased. During the inspection, we found call bells were answered promptly and staff were available to support people at all times. One person was receiving additional support from an external agency for eight hours a day to help meet their individual needs. A community nurse who supported the person told us clear lines of responsibility had been developed between staff employed by the provider and staff employed by the agency to help ensure the person received consistent support.

Requires Improvement

Is the service effective?

Our findings

People told us they felt they received effective care from staff. One person said, "Care staff look after me pretty well, they're alright". Another person told us, "Everyone is well cared for." A community nurse who had regular contact with the home told us, "Staff abilities [to support one person] have grown from working with [the person]. They give [the person] clear information and give them time to respond."

However, we found not all staff were suitably trained. Training records showed that staff had not completed or refreshed their training, in line with the provider's policy, to equip them for their role. For example, a staff member who had worked at the home for five months had not received any training apart from moving and handling training, yet were expected to take charge of the shift at night. A care staff member, who had been in post for a year, had also only completed moving and handling training. Other staff, who had worked at the service for over a year, had not refreshed essential training such as safeguarding and infection control training. Staff who administered medicines had not always completed relevant training, as detailed in the Safe section of this report. Where staff had completed the training, but failed the knowledge check at the end, the registered manager told us they should repeat the training and the knowledge check. However, we found this did not always happen. For example, one staff member had failed their safeguarding training in two successive years, yet had not re-done it in either year.

The failure to ensure staff were suitably skilled and received appropriate training was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

New staff completed an induction into their role. This included time spent shadowing, (working alongside experienced staff) until they felt confident they could meet people's needs. Staff who were new to care were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. A senior staff member told us they were being supported to achieve a level five management qualification in health and social care.

Staff told us they felt supported in their roles by the registered manager, who they described as "supportive" and "brilliant". One staff member told us, "Me and [the registered manager] talk most days. He is there if needed and is very approachable." Staff had annual appraisals where they discussed their performance and development needs, together with occasional sessions of supervision with the head of care to discuss their progress and any concerns they had.

People had mixed views about the food. Comments included: "The food isn't bad, but it is a bit like school dinners; cake and custard", "It's moderate. There isn't enough variety, but it isn't too bad", "The food is very good and that there is a lot of choice" and "The food is really good. They [staff] are very accommodating. If I don't like the main meal, the cook will do me something else".

However, staff were unable to confirm that the dietary needs of a person living with dementia, who they had placed on a pureed diet six months previously, were being met. Staff told us they had placed the person on a

pureed diet as they had not been eating well and had expressed an interest in another person's meal that was pureed. However, the records of the person's food intake showed they frequently ate little or nothing of the pureed meal offered and the decision to puree their meals. There was no record to show the person's GP had been informed about the person's poor appetite, although staff said they had done this, and the person had not been referred to a speech and language therapist to consider their need for a pureed diet. The person's nutritional care plan advised staff to offer the person frequent snacks, but the food records showed these were not offered regularly. The person had lost their false teeth, but staff were unable to tell us when this happened or how long the person had been waiting to see a dentist. These failings meant staff were not able to demonstrate that they had done all that was practicable to meet the person's dietary needs.

People were offered a choice of meals, but this was not done in an effective way for people living with dementia. The choices were offered two to three hours before the meal, which meant people might not remember their choice and supportive information, such as pictures were not used to help people with a cognitive impairment make an informed choice. A staff member acknowledged that some people became confused when menus were discussed and others struggled to hear the options due to impaired hearing.

Where people were at risk of not drinking enough, staff kept records to monitor how much people consumed. However, the records were not always completed fully. For example, records showed that on one day, a person was only offered two drinks of juice with a total daily intake of 200mils and no drinks were provided after lunch until the next morning. On another day, the person had a daily recorded intake of 350mls. Staff assured us the person would have drunk more than that, but the lack of accurate records meant this was not monitored effectively. In addition, staff did not add up the total amount people had drunk each day to help identify when people needed to be referred to healthcare professionals for advice. We discussed this with the registered manager who agreed to address the recording issues with staff.

The failure to ensure people's dietary and hydration needs were met in a personalised way was a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The dietary needs of most other people were met, however. For example, one person required a gluten-free diet and we saw this was provided consistently. Staff monitored people's weight to identify unplanned weight loss and took appropriate action, for example by fortifying meals to enhance their calorific intake.

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

During the care planning process, senior staff had assessed people's capacity to make specific decisions, such as to receive medicines or personal care and usually documented decisions they had made in the best interests of people. However, we found two people had been moved from single rooms into shared rooms, which the registered manager said this had been done for "safety reasons". However, there was no record to show whether the person, or their representative, had been consulted or why such a move was in the person's best interests. In addition, staff were restricting the fluid intake of one person, for medical reasons, but the person's ability to agree to this decision had not been assessed. Their ability to make a further decision, relating to the use of a seat alarm to monitor their movements, had also not been assessed. We discussed these issues with the registered manager, who agreed to complete and document the necessary assessments.

Staff described how they sought verbal consent from people before providing care and support and said they acted in the person's best interests. If a person declined the support offered, staff said they would withdraw and try again later or ask a different staff member to offer support. Where people had capacity to consent to specific decisions, we saw they had signed 'consent forms' confirming their agreement to the care and support they were receiving.

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

Some adaptations had been made to the home to make it supportive of the people who lived there. For example, a passenger lift was available for people to use, handrails were provided along corridors and bathrooms had large signs on the doors to make them easier for people to find. However, other aspects of the environment did not support people so well. One person used a wheelchair and went out most days, but the absence of a ramp meant this was not easy for them. The person had to transfer from their own purpose-made wheelchair to a lighter wheelchair that could be lifted over the home's threshold. We discussed this with the registered manager who said they would explore options for installing a suitable ramp.

Other people complained about the level of noise in the home. One person said, "There is too much noise, people being stupid and singing and dancing." While talking to another person, we heard a third person shouting loudly and making sounds in the corridor. The person we were with said they did not like this, but had "learnt to put up with it". They said the noise went on "until midnight sometimes". A further person told us they "sometimes get annoyed and offended by a resident calling out during the day". Another person complained about people continually entering their room. They said, "It's like Piccadilly Circus. Everyone is in and out. I can't concentrate or focus on anything." We saw screens had been put up in a corridor to deter one person from accessing another's room, which staff said had helped ease the problem. Most people chose to use a small lounge that staff referred to as the "coffee lounge". This was a small room, used by up to six people, where drinks and snacks were prepared. A community healthcare professional who had regular contact with the home told us this environment was "not ideal" for one person in particular. They said, "The coffee lounge is noisy and [the person] gets over-stimulated by noise, which puts other people in vulnerable situations as a result. Records confirmed incidents of conflict between people had occurred in the coffee lounge and been the subject of safeguarding investigations. The registered manager told us people had the option of using a quiet lounge, but chose not to. However, they had not explored ways to encourage and support people to use this lounge which, for most of the inspection, was completely empty.

Senior staff completed pre-admission assessments before people moved to Solent View. However, these had not always been effective in identifying the full extent of people's needs. The provider had recently admitted people on emergency placements and later found they were unable to meet their needs. This had resulted in safeguarding concerns being raised by family members about the care and support their relatives received. One of the family members affected by this told us, "We weren't asked for any information about [my relative's] needs. [The registered manager] has accepted they couldn't meet [my relative's] needs and shouldn't have taken them." The registered manager told us they had made a decision not to accept emergency placements in future, in order to avoid such a situation arising again.

People were supported to access healthcare services when needed, with the exception of speech and

language therapists and a dentist, as mentioned above. People were also supported to attend, or accompanied to, medical appointments. Records confirmed that people were seen regularly by doctors, community nurses and chiropodists. During the inspection, staff were not happy with the response they received from an external healthcare professional, so later called an ambulance for the person, who was admitted to hospital for observations. A GP who had regular contact with the home confirmed that staff called and referred people to them appropriately.

There were procedures in place to help ensure that people received consistent support when they moved between services. In addition, the registered manager showed us work they were doing to introduce 'hospital passports' to help ensure all relevant information about people's needs would be available in the event that they needed to be admitted to hospital.

Staff made appropriate use of technology to support people. For example, pressure mats and seat alarms were used to alert staff of the need to support people when they moved to unsafe positions. Special pressure-relieving mattresses had been installed to support people at risk of pressure injuries and an electronic call bell system allowed people to call for assistance when needed.

Requires Improvement

Is the service caring?

Our findings

We received mixed views from people about the manner and attitude of the staff. Comments from people included: "The staff are very friendly, everyone is tip-top", "The staff are marvellous, they are so good. They understand me, they are lovely" and "The [staff] are lovely, we have a joke and a laugh". However, one person told us, "The carers are very nice [although] one or two are a bit off-hand" and another person said, "[Staff] are lovely as people. One [staff member] doesn't want to deal with me now that my needs have changed." The family member of a person who had recently stayed at Solent View told us staff were sometimes "unhelpful" when they asked for support, for example "tutting and slamming pens down on the desk when we asked them to take [my relative] to the toilet."

We observed some positive interactions between people and staff. For example, when a person became distressed, calling out from their room, a care staff member stayed with them for a while, talking calmly and soothingly to reassure. Staff used people's preferred names and were patient when supporting them to mobilise. The family member of a person who had died at the home a year previously told us they were encouraged to visit the home every day for lunch. They told us they gained comfort from visiting and keeping in touch with staff and other people living at Solent View. A healthcare professional told us staff had developed "a good rapport" with a person with specific communication needs.

However, we noted staff sometimes used inappropriate language when talking about people, which demonstrated a lack of respect. For example, during a handover meeting between shifts, a staff member referred to a "dirty nappy" when talking about a person's continence pad; and we heard another person being called a "good girl". In one person's daily records, staff had described the person as "horrible" when they had displayed behaviour that had challenged the staff member. Other daily records recorded that one person had "refused" to go to bed and another person had been "sent to [their] room" after a confrontation in the lounge. The registered manager felt the phraseology used reflected some staff members' inability to express themselves clearly, rather than a lack of understanding of people's support needs, but they agreed to work with staff to improve this.

Some staff showed a lack of consideration for people's dignity. Some people living with a cognitive impairment required staff to organise and care for their clothes. When we looked in their bedrooms, we found their clothes had sometimes been pushed into drawers, unfolded, making it difficult to open the drawers. The family member of a person who recently spent time at the home told us, "[My relative's] drawers were often in a pickle, with clothes screwed up and unfolded." One person's room was untidy and disorganised, with boxes of continence pads stored on the floor in clear view of visitors and people passing by the room. In this room and in other people's rooms we saw toilet rolls on tables and chests of drawers. In another person's room was a box of convenes, together with boxes of tubing and urinary drainage bags for use with convenes, also in view of visitors and people passing by. A convene is a sheath used to manage male urinary incontinence. In a further person's room, we saw unused continence pads had been left on a chair and beside their television. Staff had not recognised that these issues compromised people's dignity.

People told us staff respected their privacy when providing person care. For example, one person described

how staff covered them with towels when supporting them to wash and we saw doors were always closed when people were receiving personal care in their rooms. However, we found staff were not always discreet when talking about people between themselves in communal areas. For example, at lunchtime on the first day of the inspection, we heard staff discussing how much people had eaten and who was being supported to use the bathroom. At other times, though, individual staff members were more considerate and offered people support in a quiet, respectful way. Confidential information was not always kept securely. The 'nurses' station' was on the ground floor close to a toilet used by people throughout the day. Personal information about people, such as care plans, medicine administration records and medical appointments, was often left in full view of people or visitors.

The failure to ensure people were treated with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff supported people to maintain their independence by encouraging them to do as much as possible for themselves. One person told us, "When I have a shower, they [staff] do my back and lower legs, but leave me to do the rest." A staff member described how they promoted independence when supporting people with personal care by encouraging them to choose their clothes, to dress and to use the bathroom independently. Another staff member said, "If you give [one person] a flannel and a towel, they can wash themselves with a little prompting. We just need to wash their back."

The registered manager told us they explored people's cultural and diversity needs during the pre-admission assessment process and during conversations about their backgrounds. For example, the care plan for one person provided an insight into their cultural background and how the person liked to be referred to in this respect. When we spoke with staff, they were aware of the person's background and confirmed they supported them in accordance with their wishes. The staff training programme included a module about 'equality and diversity', although we found only 13 of the 23 staff employed had completed this. The registered manager acknowledged this was an area for improvement to help staff understood how to identify and meet people's cultural and diversity needs.

Most people and relatives told us they were involved in discussing and making decisions about the care and support they received. One person told us, "I've taught staff how I want things done and most have listened. Some have taken a little longer to grasp it, but most are okay." Reviews of people's care plans were completed regularly. Although staff told us they usually consulted people and their relatives as part of the review, we found their views and comments were not recorded. The registered manager acknowledged this and took action to help ensure people's views were documented in future.

Requires Improvement

Is the service responsive?

Our findings

People told us they received personalised care and support that met their needs. One person said, "One or two staff do not know how to deal with me and rush me; but I can't be rushed [due to a medical condition]. Other staff have a way of dealing with me and I don't feel rushed. One [staff member] has cared for a patient with [my condition], so gets it."

People's care plans contained information to enable staff to support people in an individualised way and were reviewed every month or sooner if the person's needs changed. They included information about what person could do for themselves and what they needed help with, such as in relation to personal hygiene. Staff recognised that people's needs varied from day to day and tried to accommodate this. One person told us, "Some staff are better than others. Every day can be different, but most [staff] can accommodate my [varying needs]." A staff member said, "[One person's] mood changes each day. They can be independent some days and other days not. We have to look for the reasons behind it, for example if they're tired or if the family have not visited."

When we spoke with staff and listened to them during a handover meeting between shifts, we found they had a good understanding of people's individual needs. For example, they knew that one person was reluctant to eat and drink and discussed ways to overcome this. They knew that another person frequently became unsettled in the evenings and needed more support at this time.

However, records of the care staff provided to people were not always adequate to confirm that people's needs had been met. For example, one record stated that a person had been "calling out all afternoon", but there was no record to show what action staff had taken to support the person. We observed that another person frequently called out or talked loudly in their room, but staff did not respond or offering reassurance. The person's care plan did not contain any guidance to staff about how to support the person with these behaviours. Although 'incident records' were kept, these did not identify the triggers for the behaviour or the interventions that might help. The same was true of another person who frequently became agitated and "aggressive" towards staff. Although their care plan advised staff to "approach with a positive attitude" and "take [the person] for a walk when possible", records showed this was not done consistently. A staff member told us, "We will walk [the person] around, but it's not enough for them and we don't have time to walk all round the building with them." The absence of meaningful monitoring charts meant staff had not been able to develop strategies that provided effective support to people when they became distressed.

Four people were being cared for in bed and were unable to use their call bells due to cognitive impairment. Staff told us they regularly checked these people to make sure they were comfortable and to offer drinks. However, there was no system in place to help ensure this happened consistently. This posed a risk that one staff member might assume another had checked the person when they had not and vice versa, leading to the person not receiving support over an extended period.

The failure to ensure people received personalised care and support that met their needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not given information about how to raise concerns or complaints with the provider. The family member of a person who had recently stayed at Solent View told us staff were sometimes "dismissive" of them when they raised concerns. For example, they told us, "When we found [my relative] in a urine soaked bed, the attitude of staff was poor. When we asked why they were wearing someone else's clothes, the staff member just said, 'Well I didn't dress [the person] this morning'. We were never given any information [about the service] or about making complaints."

The provider's complaints policy was included within the service's Statement of Purpose. The registered manager acknowledged this was not usually given to people or family members, but was available in written format on request. We found neither the complaints procedure, nor the provider's Statement of Purpose was advertised within the home and a version that would be accessible to people with cognitive impairment had not been developed. The registered manager told us that no complaints had been received in the past year, as people "go straight to you [CQC] or Safeguarding". CQC records confirmed that concerns about the service had been raised by family members and had not been reported to the provider.

The failure to operate an accessible system for identifying, receiving and recording complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to describe the key aspects of end of life care and said they supported people at the end of their lives to have a comfortable, dignified and pain-free death. This was confirmed by a family member who told us their relative had received "wonderful" end of life care and that their death had been "very peaceful". However, we found few staff had completed end of life training. They had not explored people's end of life wishes and preferences with them and there was insufficient information about this in people's care plans. This posed a risk that people's preferences might not be known or respected, particularly if they had to be transferred to hospital or other care setting in their final days. The registered manager acknowledged this was an area for improvement and said they were encouraging staff to enrol on an extended end of life training course at a local hospice.

People had access to a limited range of activities. One person told us, "We do activities like making things, but it's more a case of what's on offer than what I want. I'd like to go out for coffee, but we can't do that. We only go out for medical appointments." Care files contained information about people's hobbies and interests and prior life history. In some cases, this information had been used to tailor activities to meet people's interests. For example, some people had expressed an interest in particular crafts and these had been arranged and a CD player was used to play a person's favourite music. There is a plan of activities every week, although the majority of people chose to stay in their rooms and engaged in one-to-one discussions with the activities coordinator.

Staff told us they encouraged people to make choices about aspects of their lives, such as when they got up and went to bed and where they spent their day. One person told us, "I choose all my clothes. Clothes are important to me, so [staff] wash them separately for me." This showed staff were aware of things that were important to people and respected their wishes.

Inadequate

Is the service well-led?

Our findings

People told us they were happy living at Solent View and felt it was well-led. Comments included: "The [registered] manager has helped me out a lot, I get on with him well." A family member told us, "Things are run well." However, a family member whose relative had recently spent time at the home told us the home was "not well-led". They said, "[My relative] had an awful experience. We would find her in tears. It was heart breaking."

We found the governance arrangements were not effective in ensuring the provider met fundamental standards of quality and safety at the service. The service was operated by two directors of the provider's company, who were also the registered manager and the head of care. However, there was a lack of resilience in the management structure as the head of care was not always available. For example, they had not visited the service in the two months prior to this inspection and responsibilities allocated to them were not covered in their absence. These included taking the lead for infection control and providing advice to staff about how to support people with more complex care needs. As a consequence, we found significant concerns with infection control arrangements and identified that some people's care needs were not being met. The registered manager acknowledged it was "harder to keep an eye on things" when the head of care was absent.

The provider did not have an effective quality assurance system in place to assess, monitor and improve the service in a sustainable way. Following an inspection in 2015, the service was rated 'Inadequate' overall and placed into Special Measures. At the following inspection, in 2016, we found improvement had been made and the service was taken out of Special Measures. However, this improvement had not been sustained.

Auditing processes were not robust. Although care plans were reviewed each month, the reviews had not identified the absence of some mental capacity assessments for people, the absence of a clear system to ensure people being cared for in bed were checked regularly, or the inaccurate recording of people's falls. The monthly environmental audit had not identified that one person's radiator was not protected, thereby putting the person at risk of harm. Infection control audits had not been completed, so the provider had not identified cleanliness and cross contamination issues or that the laundry room was not fit for purpose. Medicine audits were also not completed, so the provider had not identified that people did not always receive their medicines as prescribed or that topical creams were not managed safely. Although a staff member monitored the completion of staff training, this had not been effective in ensuring that all staff training remained up to date. As a result, we found some staff had not completed essential training, including medicine administration. There was no system in place to oversee staff recruitment to ensure staff did not start work until all pre-employment checks had been completed. There was no system in place to monitor the effectiveness of the complaints procedure or to ensure it was accessible to people. These failures contributed to the eight breaches of regulation we identified at this inspection.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Providers are required to act in an open and transparent way when people come to harm. This includes a requirement to provide information, including an apology, in writing to the person or their representative. The registered manager told us they were not aware of the need to do this. They did not have a duty of candour policy in place and had not provided any information to people in writing after they had come to harm.

The failure to provide written information and follow duty of candour requirements was a breach of Regulation 20 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Although they had not provided written information, the registered manager had given the information verbally to people and had reported relevant incidents to CQC and to the safeguarding authority. They had also displayed their previous inspection rating of 'Requires improvement' in a prominent place by the front door. This demonstrated a commitment to being open with people.

The provider sought feedback from people using questionnaire surveys every six months. Feedback from the July 2017 survey showed people were dissatisfied with the laundry arrangements as clothes were sometimes lost. Following this survey, a new system was introduced to mark people's clothing with coloured threads. This showed the provider had acted on feedback from people. However, the January 2018 survey indicated that missing clothing was a continuing concern. The measures introduced had not been successful and the registered manager told us they would review the issue again.

Staff told us they worked well as a team and supported one another. One staff member said, "We're like a little family. We work well together." However, we found there was a lack of organisation in the staff team. Staff were not allocated to particular tasks or responsibilities each shift. One staff member told us, "We just check people regularly and talk to each other. There's no process." This posed a risk that some key tasks might not be completed as one staff member could assume another staff member had done it and vice versa.

Staff were happy in their work and told us they felt supported by the registered manager, who they described as "brilliant" and "approachable". One staff member told us, "[The registered manager] is brilliant, spot on, always there at the end of the phone. I've never worked for someone like him." Another staff member said, "[The registered manager] is a great boss, really supportive." Regular staff meetings were held and provided opportunities for staff to make suggestions for improving the service. One staff member told us, "I'm always bringing up ideas. We all want the best for residents." The most recent staff meeting included a discussion about staffing levels and had led to these being increased. Staff had also been given note books to help them keep more accurate records of the care they gave.

Throughout the inspection, the registered manager was open about the challenges they faced. To help address some of the challenges, they had recently employed an administrative assistant. They had also attended a five day course to support them in the management of the service and were enthusiastic about improvements they wanted to implement. Following the inspection, they sent us an action plan detailing how they would address the more significant concerns; they also contacted the Clinical Commissioning Group (CCG) and one of their peers for support and advice.