Coate Water Care Company (Church View Nursing Home) Limited

Church View Nursing 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

We carried out this inspection over three days on 9, 11 and 18 January 2018. The first day of the inspection was unannounced.

There have been five inspections of this service since the beginning of 2015. In May 2015, four warning notices were issued, the service was rated inadequate and placed in special measures. Improvements were seen in October 2015 but at the inspection in March 2016, not all had been sustained and further shortfalls were identified. Due to this, we imposed a condition on the home's registration. This required the provider to undertake regular monitoring of the service and inform us of their findings. The provider has fully complied with the condition and sent us the information as required.

The last inspection of this service was on 25, 26 January and 2 February 2017. Improvements continued to be made but we issued a requirement notice in relation to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because decision making, for those people who did not have capacity, was not always undertaken in line with the Mental Capacity Act 2015. At this inspection, improvement in this area had been made. However, documentation did not always clearly evidence the best interest decision making processes, which had been undertaken.

Church View Nursing Home is registered to accommodate and provide nursing care for up to 43 people. If the twin rooms were used for single occupancy, 36 people could be accommodated. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. On the day of our inspection, there were 33 people living at the home. Church View Nursing Home has bedrooms on the ground and first floor. All rooms have en-suite facilities. A passenger lift is available for people with mobility difficulties. There is a communal lounge and dining area on each floor with a central kitchen and laundry room.

There was a manager in post. They had worked at the home for approximately seven months and were in the process of registering to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager and another manager who was also in the process of registering, to become the registered manager, were both available throughout the inspection.

People's medicines were not safely managed. Whilst administering medicines, the staff member did not ensure safe practice. This was because they gave the medicines to another member of staff to give to the person. One medicine was inaccurately labelled, which had not been identified and another was out of date. Another person had not received their night time medicines but staff had recorded they had been given.

A range of audits were in place to assess the quality and safety of the home. These assessed areas such as infection control, health and safety, medicines and the dining experience. There was a continuous improvement plan and the manager submitted a monthly management report to senior managers. However, whilst these structures were in place, the shortfalls we identified particularly with medicines, had not been identified.

Staff were happy with the amount of training they received and felt well supported. They were aware of their responsibilities to keep people safe and to report concerns as required. Training records were in the process of being developed as they did not effectively show what courses staff had completed.

Improvements had been made to people's care plans. The support people required to meet their clinical needs was well written. Wound treatment plans were clear but other areas of people's support were less detailed. There was limited information about a person's resistance to care and the use of restraint. New initiatives were being implemented to develop more person centred care plans.

The support people received had improved. Care plans gave staff clear information about reducing people's risk of pressure ulceration. Staff had fully completed care charts to evidence the support they gave. All pressure relieving equipment was set correctly and regularly checked.

People enjoyed the food and were supported to have enough to eat and drink. People had a choice of food and alternatives were provided, if they did not like what was on the menu. Records showed those people at risk of malnutrition or dehydration, were given additional support and their intake was regularly monitored. Concerns were reported to the required healthcare professionals.

There were sufficient numbers of staff to support people effectively, although there was some reliance on agency staff. Successful recruitment was addressing this. Staff were not rushed and answered call bells in a timely manner. The home was calm and relaxed. The majority of people, relatives and staff told us there were sufficient staff available.

People and their relatives were complimentary about the cleanliness of the home. All areas, including those less visible, were clean and there were no odours. Effective cleaning schedules were in place and staff were aware of procedures to minimise the risk of infection. A system for the laundering of hoist slings was implemented when it was brought to the manager's attention.

People spoke about staff and their caring nature, in a positive manner. Staff were friendly, caring in their approach and respected people's privacy and dignity. There were positive interactions and some light hearted banter, which people responded to well.

We found two breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. One of these was repeated from the last inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not safely managed.

Risks to people's safety had been identified and addressed.

Sufficient staff were available to meet people's needs.

Safe recruitment practices were being followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements had been made with regards to decision making but documentation did not evidence best interest decisions were in line with the Mental Capacity Act 2005.

Staff received training to help them do their job effectively and were well supported.

People were complimentary about the food and had enough to eat and drink.

People received good support from various health care professionals to help them remain healthy.

Is the service caring?

Good

The service was caring.

People spoke positively about the care they received and were complimentary about the staff.

People were encouraged to follow their preferred routines and their rights to privacy and dignity were maintained.

There were positive interactions and staff were passionate about providing a high standard of care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

New initiatives were in place to develop person centred care planning.

Some care plans were well written but others lacked detail.

People and their relatives were happy with the care provided.

People were confident any concerns would be fully investigated and addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A detailed auditing system and on-going improvement plan was in place. However, shortfalls found at this inspection, had not been identified.

There was a clear management structure with two new managers in post, who were in the process of being registered with CQC to become the registered managers.

There was a clear vision with an emphasis on people's involvement.

Church View Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 9, 11 and 18 January 2017. The first day of the inspection was unannounced.

The inspection was carried out by three inspectors, a pharmacy inspector, a specialist advisor who was a nurse 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. One of the inspectors was present throughout the inspection. The others attended on the first day only.

In order to gain people's experiences of the service, we spoke with 17 people, 8 relatives and one health/social care professional. We spoke with two senior managers, two managers and 15 staff. After the inspection, we contacted four health/social care professionals for further feedback. One of these professionals responded.

We looked at people's care records and documentation in relation to the management of the home. This included staff training and recruitment records and quality auditing processes. We looked around the premises and observed interactions between staff and people who used the service. We did not use the Short Observational Framework for Inspection (SOFI). This was because people were able to share their views and those who could not do this, were in their rooms and not in communal areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in January 2017, errors had occurred with people's medicines despite improvements being made to the medicine administration systems. After the inspection, information from anonymous sources raised concerns about the overall safety of the medicines management. In addition, three medicine errors had occurred and on one occasion, people did not receive their evening medicines due to an emergency in the home. Appropriate action in the form of additional training or disciplinary action was taken when the medicine errors were identified.

At this inspection, medicines were not always safely managed. During a medicine round, one member of staff removed a person's medicines from the monitored dosage system. They then gave the medicines to another staff member to give to the person, and signed the medicine administration record, although they had not seen the person take their medicines. This process was repeated for each person. Senior managers told us this was not usual practice but a staff member was inducting another, before they were allowed to administer medicines on their own. Delegating the medicine administration to a second person did not provide assurance that they were competent to do so and increased the risk of error.

A medicine administration record showed staff had administered a person's night time medicines. This was not accurate, as the four tablets remained and were stored separately to other medicines. In addition to the person not receiving their medicines as prescribed, effective monitoring was not assured. Within another administration record, an oral medicine was described as an infusion, which was to be given intravenously. This was an error, which increased the risk of the medicine being given by the wrong route. Staff had failed to identify this.

Another medicine had been discontinued but it was stored with people's current medicines. The medicine had passed its expiry date, which had not been identified. Staff had handwritten medicine administration records for some people but one was not clear. This was because it did not give the dosage directions to show how and when the medicine was to be given. Staff had not signed the record and it had not been countersigned by another member of staff. This did not ensure the instruction was correct and increased the risk of error.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

There was an effective process to manage conditions of people who were prescribed higher risk medicines such as anticoagulants. Anticoagulants are medicines prescribed to prevent blood clots. Guidance was in place for staff to give people their medicines "as required". This enabled staff to identify symptoms and offer medicines to people if they needed them. Staff received training in medicines management and had their competency assessed.

Risks to people's safety had been identified. There were up to date assessments, which detailed areas such as the risk of pressure ulceration, malnutrition, falling and choking. Where risks had been identified, the majority of care plans provided staff with guidance on how to keep people safe. However, one person had

been assessed as being at risk of choking. Their care plan lacked clarity as it stated "needs to be supervised" and "only takes a few spoonfuls at a time". There was no other information such as the person's posture whilst eating and drinking. Another care plan stated "ensure thickener is added to fluids". The information did not show how much thickener the person required in their drinks. This detail was identified on the dispensing label of the thickener but staff said this was not always the case. This was confirmed as a tub of thickener for another person stated it was to be used "as directed". On the second day of the inspection, senior management told us all information about the risk of choking had been updated to ensure clarity. They said staff had been reminded of the use of thickener and were aware of each person's requirements.

Improvements had been made to minimise the risk of pressure ulceration. Assessments, which had been regularly reviewed, identified each person's level of risk. Information then showed what support each person required to ensure healthy skin. This included pressure relieving equipment and the frequency the person needed to change their position. Staff had completed care charts to show the support they had given people. This was in line with their care plan. Pressure relieving mattresses were set correctly and there was a system in place to check these daily.

People told us they felt safe and risk was well managed. One person told us "Staff definitely know what they are doing and how to handle me" Another person said "There is always somebody on hand to help. I have my call bell nearby, which gives a feeling of safety." Other comments were "I need hoisting and they are fine with this", "I use a walking frame. They help me, are careful with me and prevent me from falling" and "I feel comfortable and safe because people care. They are lovely and thoughtful." Other people told us they felt safe as the building and their possessions were secure. Relatives had no concerns about their family member's safety. One relative told us staff encouraged their family member to be independent but measures had been put in place to promote safety. Another relative said "She's as safe as she'll ever be. I don't worry about her safety at all."

Staff knew how to identify abuse and report any concerns, including poor practice, to management or other agencies. Reporting procedures were displayed on notice boards for reference. Records showed concerns about people's safety had been appropriately reported to the local safeguarding team. Measures such as further training or disciplinary action had addressed shortfalls. Staff told us they had received safeguarding training although records showed two staff had not completed this.

Infection control was generally well managed. However, at 09.55 on the first day of the inspection, there was a soiled incontinence aid at the bottom of one person's bed. Staff removed this quickly, when it was brought to their attention. In addition, there was no formal system for the laundering of hoist slings. Staff told us each sling was sent to the laundry when soiled, rather than on a structured, planned basis. Records to show the laundering of the slings were not maintained. On the second day of the inspection, this had been addressed and a formal system had been implemented. There was a waste paper bin in the visitor's toilet which was not foot operated due to its position. Senior management told us a range of bins had been purchased but had not been effective due to the space available. They said they would look at another suitable alternative.

The home including less visible areas was clean and there were no odours. People were complimentary of the home's cleanliness. One person said "My room is fine, nice and clean. Cleaner comes in, has a nice chat to me. No problem with cleanliness." Other comments were "The girls do a good job of keeping my room clean. It is always nice", "Very, very clean. The whole place is properly clean" and "Always clean and tidy, everywhere." Relatives were equally complimentary about cleanliness. They told us "It's always spotless. They do a fantastic job" and "Her room is always spotlessly clean. There's never any odours."

Cleaning schedules were in place and staff signed these when they had completed each task. Staff said they could help themselves to personal protective equipment such as disposable gloves and aprons when required. They were aware of the processes in place to minimise the risk of infection. This included the safe handling of soiled laundry. Hand sanitising gels were placed at various points within the home. Staff washed their hands between tasks and prior to handling food. Infection control audits were undertaken on a six monthly basis and records showed staff had completed training in this area.

Before the inspection, we received anonymous concerns about insufficient staffing. However, on the day of the inspection, there were enough staff to support people effectively. The home was calm and staff were relaxed and not rushed. Staff were responsive to people's requests and call bells were answered in a timely manner. Those people who preferred to remain in their rooms or were nursed in bed received frequent staff visits.

A dependency tool was used to determine the number of staff required for each shift. This showed nine staff were required for the morning and evening shift and four were required for the night. One or more of these staff were registered nurses. Staffing rosters and the information senior management sent to CQC on a monthly basis showed these requirements were maintained. However, there was a reliance on agency staff to ensure staffing levels were maintained at all times. Even though the same staff were requested, the use of agency had impacted on the service in terms of consistency and skill. Staff, managers and senior managers told us agency usage was getting better and lessening each week. It was hoped with successful recruitment, a permanent staff team would be in place shortly.

Comments about staff availability were variable. One person said "Sometimes there's a long wait because the staff have such a lot to do" and a relative commented "sometimes it feels as if there are enough staff but at other times, you have to go looking for someone." A member of staff told us "The residents do get good care here but we don't always have time to sit and chat with them." Two people and two staff said whilst staffing levels were adequate, they felt it would be beneficial, to have an additional member of staff on the ground floor. Other comments were more positive and included "Life is pretty good. No long wait for help and I see the same staff", "We're relying on agency staff but we're always adequately staffed" and "There's enough staff around when you need them." A health/social care professional told us there were sufficient staff to manage the care of people although there was not always a member of staff in the lounge area, to monitor and maintain safety.

Safe recruitment practice was being followed. However, one record showed the applicant had been in their present job for only a short time but a reference from this employer had not been requested. The manager was able to explain why this was, but it was not documented. The applicant had had a number of jobs in relatively quick succession and one of their references was described as 'acceptable' rather than good or excellent. Records did not show these factors had been further explored. Another application showed the applicant had resigned from one of their positions but the reasons for this were not detailed. All other recruitment practice was ordered and checks had been undertaken as required. This included the applicant's identity, their right to work in the UK and a Disclosure and Baring Service (DBS) check. A DBS identifies if applicants are suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection in January 2017, some people were not supported to make decisions in line with the principles of the Mental Capacity Act. A requirement was made to ensure the provider made improvements in this area. At this inspection, improvements had been made but further work was required to ensure the home fully complied with the Act.

There was evidence of mental capacity assessments, best interest decisions and delegated authority of relatives who were able to make decisions on their family member's behalf. However, the process for making decisions in people's best interests was not clearly evidenced. Information was held in different places and not coordinated. For example, two people were having their medicines disguised in food or drink without their knowledge. It was not clear how the decisions to give the medicines in this way, had been reached. Another care plan stated the person's medicines could be given covertly if needed, as agreed in their best interests by the GP, home and pharmacy. There was no documentation to show how this decision had been reached. After the inspection, the manager sent us further information regarding these areas. However, one format showed consent had been given to all aspects of the person's care without further evidence of the decision making process. Another record showed a capacity assessment and how decisions had been reached but it did not specifically relate to covert medicines.

Documentation did not always show people who had been assessed as having capacity, had consented to their care. One person who had capacity had bed rails in place but they had not signed a consent form. After the inspection, the manager sent us the consent form but it was signed by a relative. This was not appropriate, as there was no evidence of the person's wishes. Another person had a Lasting Power of Attorney (LPA) in place for health and welfare. Their care plan showed a lack of understanding regarding the LPA's role of decision maker. Another person had signed a consent form for bed rails but the information did not show what other (if any) less restrictive options had been discussed.

This was a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

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).

Applications, to restrict some people's liberty under DoLS, had been submitted to the local authority. These had not been processed by the DoLS team but the manager had been proactive and requested regular updates.

People told us they were encouraged to make decisions about their care. One person said "I choose when I get up or go to bed. I am never told I have to go to bed, I decide." Other comments were "They ask me when I wake, if I would like a shower or a bath", "you do what you like" and "I do have a say whether I have care from a man or a woman." Some people who were nursed in bed told us they had the choice of whether they wanted to get up or not. One person chose not to adhere to a specialist diet, which had been recommended to them because of their health. They had been assessed to have the mental capacity to do this, despite the risks associated. The risk was managed by ensuring the person was regularly reminded of the recommended diet options.

Staff were aware of people's needs, preferences and the support they required. They said they received a range of training to help them to do their job effectively. One member of staff told us "I get access to lots of training. I've been on an end of life course. We've had tissue viability training and some training about thickeners. The training is helpful and really good. I'm starting a future leader's course soon." Another member of staff spoke about the future leader's course. They said they were doing this, as they had recently taken on more of a leadership role. Staff told us they could request any training they felt they needed.

New staff told us they had or were in the process of working through their induction. They said they had attended core training such as safeguarding, moving people safely, MCA and DoLS, infection control and emergency first aid. New staff told us they had worked with more experienced members of staff before supporting people on their own.

Whilst staff told us they had completed a range of training, it was not clearly evidenced. Certificates were not consistently stored on staff files or held electronically. A record showed the mandatory training staff had completed although one staff member had been missed from the record. The record did not show other training, related to older age or people's clinical needs. The manager told us training including records, was being reviewing as a whole with an aim to "move away" from electronic training courses. They said registered managers were in the process developing an area of interest so they could facilitate staff training. The manager told us they would be providing first aid training to all staff locally, within the organisation.

Staff told us they felt supported in their role. One member of staff told us "I feel supported. The management are good and any problems I have they help sort them out." Another staff member said "[The manager] supports me very well. We are working together to improve the dining experience for people." Staff met with their supervisor more formally to discuss their work. Records of these meetings were maintained. The sessions were usually arranged on an 'ad hoc' basis and designed to share information, rather than on-going development of staff. A senior manager told us the 'ad hoc' basis for staff supervision was deliberate and worked well.

People had enough to eat and drink. There was a choice of meal and people were able to have an alternative if they did not like what was on the menu. People had regular hot and cold drinks and snacks between meals such as biscuits, fresh fruit and yoghurts. Staff gave people assistance to eat and drink as required. Records showed people's fluid intake if they were at risk of dehydration. These were checked twice a day to ensure people were being supported effectively. A senior manager told us rather than adhering to recommended daily intake guidance, hydration was ensured by offering people a drink, every 90 minutes or less.

People's nutritional needs were assessed. If a risk was identified, the person's food intake and weight were monitored. Records showed concerns had been discussed with the GP, dietician or speech and language team (SALT). However, one health/social care professional told us the reporting of actions following a person's weight loss could be improved upon. Senior managers told us food was given high priority, as it

was an important part of a person's day. They said the the calorific value of all meals was assessed so a balanced diet was offered throughout the week. The manager told us the home was proud of the food it offered.

People told us they liked the food. One person said "They do me special omelettes. I asked for feta cheese and olives and they did it for me." Other comments were and "I enjoy the food and always get enough. I don't waste any of it" and "The food is very nice. I have always enjoyed my food here. Hot, tasty and a good choice of things." People told us the chef regularly visited them to ask about their preferences and what they wanted for their meals. One person confirmed this and said "the food is well cooked. There is a choice of things I like. They will do different things for me if I ask the chef."

People were encouraged to lead healthy lives. This included maximising independence and eating a balanced diet. People were supported to see health care professionals to discuss any health concerns. One person told us "the doctor comes round regularly. Very nice lady. You can ask to see her and she will come in." Another person confirmed this and said "I see the GP when I need one. I only have to ask." Records showed people were supported by a range of health and social care professionals. This included speech and language therapists, care managers within the mental health team, occupational therapists and chiropodists.

The environment met people's needs. The main corridors had been redecorated to create a homely feel. There were handrails within the corridors and assisted bathroom facilities. People had access to their call bell and their furniture was positioned to enable easy manoeuvrability. Staff told us a ramp was in the process of being built from an external door to the garden, so all exits were easy to use. There were improvement plans regarding the development of the environment. The downstairs lounge had been developed into a coffee shop. All surfaces and equipment within the coffee shop had been designed to enable easy accessibility for those people, who used a wheelchair. The initiative of the coffee shop encouraged engagement and increased the availability of a range of drinks and snacks. One person had received training to enable them to serve people and their relatives.

Good

Is the service caring?

Our findings

The manager told us there had been various training sessions to enable staff to look at values and person centred care. They said this had included considering the service as being the person's home and how this could be further promoted. During the training sessions, staff were asked to think about what they would need to fulfil their wishes, if they lived at the home. This was then related to people's lives and the development of support. Staff made promises or pledges to people, in order to promote the caring culture.

The manager confirmed they had an excellent staff team who were very caring in their approach. Staff agreed there was a good team, with all members working well together. They spoke passionately about wanting to provide people with a high standard of care. Specific comments were "I always think it could be my mum or nan or even me, so I give the best care I can. I hear about poor care in other places and it upsets me" and "I always treat people, as I would want to be treated." One member of staff told us "I am calm and will never be rude to people. I offer reassurance and talk things through when people are scared. It's important to be nice when supporting people." Another staff member said "I observe staff to ensure their attitude is caring. We will discuss attitude if I think they are not coming across as caring and then talk about what support they need." An external professional told us they thought the home was very homely and explained it as "home from home." They said during their visits, they had always observed staff working in a caring but professional manner. Another professional told us staff were very welcoming and friendly when they entered the home.

Staff had a clear understanding of equality. One member of staff said "It's about treating people equally and making sure you offer them the same things. For example, I would not walk in to a room and say hello to one person and not everyone else. It's important to know what people like and dislike and how they want things doing." Another member of staff said "It's about treating people fairly. Not everyone likes the same things or to do the same things. It's about treating people as individuals."

People were complimentary about the staff and their caring nature although one person said "Some carers are better than others". Other comments were "Staff are very nice. They are always helpful when I ask and speak nicely to me", "Very good staff, very helpful and kind" and "Most of the time staff are perfectly caring. We have good care." One person told us "The staff are lovely, and so kind. They make me feel comfortable when supporting me. They are wonderful with a lovely sense of humour." Another person said "Absolutely brilliant. They would do anything for me. I turned up lucky here." Relatives were equally complimentary about the staff. They told us "staff are fabulous, nothing is to too much trouble and they do everything with a smile", "Carers are so caring and understanding" and "You can't choose between the staff. They are all so different but all so caring. They are so understanding of the residents."

People told us staff always respected their privacy and dignity. One person laughed and said "Those curtains are closed in a flash if they help me with anything personal." Other comments were "They treat me like a lady" and "The carers are really good at treating me with dignity and respect when looking after me. They talk to me by name and we have a bit of banter." Staff knocked on people's doors and called out when entering. They spoke to people in a respectful and caring manner.

Staff were able to explain how they promoted people's privacy and dignity. They gave examples of ensuring people were appropriately covered during personal care and undertaking care behind closed doors. Staff said they always gained permission and talked to people whilst providing care. This included explaining what was happening so people were less anxious. Whilst staff were confident when talking about privacy and dignity, they had not noted the small notices on two of the bedroom doors. These stated the rooms were ready for a new resident even though both were occupied. The information had not been changed to show people's names. Senior management told us this was changed immediately, when it was brought to their attention.

The atmosphere of the home was friendly and relaxed. There were positive interactions between staff and people who used the service. One member of staff assisted a person to eat in a caring and attentive manner. They explained the contents of the meal and regularly asked the person if they were alright. The member of staff took their time and went at the person's pace. Staff supported another person to the lounge in a specialised chair. On entering the room, a member of staff smiled, stroked the person's arm and said "it's lovely to see you X. Are you alright?" One person was being nursed in bed. Staff entered and asked "Are you comfortable in there? You look very snug, really comfy." They offered the person a drink and asked if there was anything else they needed, before they left. The staff member left the room saying "I'll see you later." One member of staff was supporting a person who had limited verbal communication skills. They ensured eye contact and interpreted the person's body language and gestures. Another member of staff identified a person was becoming anxious and disorientated. They reassured the person and guided them to an area they could recognise more easily.

People's rooms were personalised, with a range of photographs, pictures and personal possessions. People said they were able to furnish their room as they wished. Specific comments were "I like my room. I sorted it out and everything in here is mine" and "My room is lovely, all I need. I have my own things around me." One person told us "my room is small but cosy and just right for me. It's all I want and I can have it how I want it. It does get untidy but they don't mind."

Requires Improvement

Is the service responsive?

Our findings

Since the inspections in 2015, on-going improvements had been made to care planning. At this inspection, people's clinical needs including diabetes management, tissue viability and catheter care were clearly documented. Wound care plans were detailed and well written. This enabled accurate monitoring in the terms of the improvement or deterioration of the wound.

Other aspects of people's care were less detailed and not always person centred. For example, one person had a diagnosis of depression. Whilst potential symptoms were identified, information did not inform staff on how to support the person with their mood. Another care plan identified a person was resistant during a clinical intervention. The information showed restraint could be used and staff were to hold the person's hands and legs if needed. However, there was no specific guidance for staff regarding the restraint or 'safe hold'. For example, the information did not state where staff should place their hands or what pressure should be exerted. Other than giving the person their medicines two hours prior to the procedure, there was no information about other ways to minimise the person's anxiety.

Another care plan stated "needs two staff to wash and dress." There was no other detail about the person's preferences, preferred gender of staff or personal details such as the toiletries they liked to use. One person liked to have a glass of sherry with their meal. This was not documented in the person's care plan, which meant there was a risk some staff would not be aware of the preference.
Radios were on in some people's rooms but care plans did not show what radio station or type of music people preferred to listen to. A health/social care professional told us they found the electronic care plans difficult, as not all information was to hand. They said they had to go back to ask for further information and the nurses were not always knowledgeable of the particular person being asked about.

The manager and staff told us they were aware people's care plans could be more person centred. They said they were working on this. A manager told us relatives had been asked for information about their family member's preferences. Some had given this and confirmed routines, which their family member had preferred in the past. Others gave information such as "Likes music." The information was not expanded upon to determine what type of music the person preferred. A senior manager told us an initiative, "Tell me 5", had been introduced to promote person centred care. They explained all staff were being asked to say something they knew about a person, such as "Likes pink." Consideration would then be given to ways in which this could be introduced.

Staff told us they were committed to ensure the end of a person's life was comfortable and pain free. They spoke with compassion and showed close relationships with people had been developed. One member of staff told us they always continued to talk to the person who had passed away, as if they were still alive. They said it was important to show dignity and respect as they were "still that person." A relative described staff as being "fabulous, so caring and compassionate" when providing end of life care. They said "the staff really cared about [name of family member] and cared about us."

Staff confirmed they supported relatives as much as possible and worked with health care professionals to

ensure the person was comfortable at the end of their life. People's wishes after their death were recorded in their care plan. However, there was limited detail about their preferences, as their health deteriorated. A senior manager told us they believed the initiative "Tell me 5" would help develop this. People's wishes regarding resuscitation had been sought but information about one person was conflicting. This was addressed, as soon as it was brought to the manager's attention.

Staff interacted with people well and there was conversation and light hearted banter. During the inspection an exercise class, bean bags games, ball games and a quiz took place. The manager told us a new activities organiser had been appointed. Until they started, care staff supported by an activities organiser from another home, arranged all social activity. The manager told us once the new activities organiser was familiar with people, a specific programme would be developed to meet each individual's needs. A health/social care professional told us there always appeared to be something going on in the home in regards to activities and opportunities to go into the local community.

People told us they enjoyed the activities that were arranged. One person told us "They have activity people come in from outside. They sing, play instruments and do exercises with us. There's quite a bit going on really." Another person said "I join in with the activities. I like to sing and love reading. People bring in books for me and we have a library here." Another person told us their wellbeing had improved as a result of the activities they joined in with. They told us "I couldn't do anything. Now I can move my hands and I have started reading."

People and their relatives knew how to make a complaint. They were confident they would be listened to and their concerns would be properly addressed. Specific comments were "I've never really complained. I have no worries here but if there are small things, I know carers or the manager will deal with them" and "[name of manager] would sort it." One person told us a member of staff tried to assist them to get up too early. They told us "I had my say. It didn't happen again."

Staff told us if they received a complaint, they would pass it to the manager to deal with. Records showed complaints had been acknowledged and properly investigated. There was a copy of the complaint procedure on the notice boards within the home. A senior manager told us the complaint procedure was in an "easy read" format and available throughout the home.

Requires Improvement

Is the service well-led?

Our findings

The manager had worked at the home for approximately seven months. Another manager, who was the registered manager of another service within the organisation, was providing additional management support. Both managers were in the process of registering with CQC to become registered managers of the home. They said they had their own individual responsibilities but worked closely together. Senior managers continued to have strong involvement in the service and maintained a clear oversight. They said their personal telephone numbers were available to staff and relatives, so they could be contacted at any time if required.

A detailed auditing system and on-going improvement plan was in place. However, shortfalls found at this inspection, had not been identified. The audits checked areas such as health and safety, infection control, medicine management and the dining experience. Whilst the audits were effective in identifying shortfalls, not all had clear action plans. For example, in November 2017, it was identified the home required a stair evacuation seat or trolley. This had been outstanding from the previous health and safety audit and was highlighted as a level 2 priority. There was no evidence this had been addressed. A senior manager told us following an audit, any action required would be addressed immediately if at all possible. If this was not the case, it would be transferred to the continuous improvement plan rather than an individual action plan. Senior managers told us the shortfall would only be removed from the plan once fully completed and signed off. They said in the future, they would ensure the improvement plan was attached to original audit. This would evidence any identified shortfalls were being addressed. In addition to the ongoing improvement plan, the manager submitted a monthly management report to senior managers. This gave an overview of the service including the number of falls, infections, safeguarding referrals and staffing information.

There were clear systems in place regarding the maintenance of the home. Checks regarding fire safety, equipment and areas such as legionella were well managed. There were comprehensive records in place to evidence the checks undertaken. The information showed all actions taken and lessons learnt. This included informing staff during their induction to release fire doors properly after a mechanism was damaged through poor handling. Attention was being given to improving the environment for people. This included the decoration of the corridors to create a homely feel. One relative told us they were pleased that investment was being given to the environment.

There were clear processes in place regarding the day to day management of the home. Meetings were held each morning to discuss areas such as appointments or any wound dressings to be undertaken. There were regular staff meetings, including those for the heads of department, which were held on a weekly basis. Handovers took place at the start of each shift and managers made planned intervention checks twice a day. This was to ensure people had been supported to have sufficient food and fluid and their position had been regularly changed, if they were at risk of pressure ulceration.

The manager had a clear vision of how they wanted the home to be developed. This included increasing the involvement of others in relation to improvements to the environment, social activity and person centred care. They were in the process of drawing up plans for the upstairs lounge to be transferred into an American

Diner. The idea had been suggested by people and had followed a similar initiative on the ground floor, where an area had been turned into a coffee shop. The manager told us there was a clear focus on developing the home, staff recruitment and reducing the amount of agency used, to ensure sustainability. They said they wanted the home to offer an outstanding service so staff wanted to work at the home and people wanted to live there.

People were complimentary about the management team. One person told us "The manager is my mate. I can discuss anything with him and he will always put it right." Another person said "It's well managed. I see the managers. They say good morning. Both mangers are very good." One relative told us they felt the management and leadership of the home was beginning to "take shape" and make an impact. A health care professional gave us similar views. They said "The home is much more relaxed lately. Staff are chilled and there is less tension so this has impacted on the residents."

Staff told us they received good support from the managers. They particularly commented about the manager who had day to day responsibility of the service. Specific comments were "He listens and wants our ideas. He'll also address things and is very supportive" and "The manager is good. He wants to move things forward. He is good with sharing information with us. He is very positive." The manager confirmed they had an 'open door' policy and wanted to gain ideas from staff about developing the service further. They had arranged 'surgeries' so staff could 'drop in' on an informal basis to discuss their views.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Documentation did not show those people who did not have the capacity to make certain decisions, were supported in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not safely managed.