Care Quality Commission

Avante Care and Support Limited

Northbourne Court

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**

Overall summary

This inspection took place on 08, 09 and 10 April and was unannounced. At the last inspection on 11 March 2014 the provider met all the requirements for the regulations we inspected.

Northbourne Court is a purpose built residential care home which can accommodate up to 120 older people, some of whom are living with dementia. At the time of our inspection there were 109 people living at the home.

The previous registered manager had left in October 2014 and a new manager was appointed in February 2015. They told us they were submitting an application to register as 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.

We found breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of medicines, staffing and arrangements to follow the Mental Capacity act 2005.

Medicines were safely stored and most were safely administered, although, we found procedures for the safe

Summary of findings

administration of medicines had not always been correctly followed. Not all staff were aware of the correct methods for the disposal of medicines. There was not always evidence that people's capacity to make specific decisions had been assessed. There was not always enough suitably qualified staff to meet people's needs on some units at meal times. You can see the action we have asked the provider to take at the back of the full version of this report.

There were some areas that required improvement. While care provided to people met their needs, records about their care were not always fully completed or up to date and did not always evidence their or their relative's involvement in the plan of their care. We have made a recommendation to the provider to obtain further specialist advice in relation to water temperatures and checks to reduce risk of legionella.

People felt safe using the service. Staff were knowledgeable in recognising signs of abuse and knew how to report any concerns. Assessments were undertaken to identify people's health and support needs and any risks to people who used the service. Plans were in place to meet people's support needs. Safe recruitment procedures were followed and there were clear arrangements in place to deal with emergencies.

Staff respected people's privacy, dignity and independence and engaged with them in a caring manner. They understood and responded to people's diverse individual needs and were familiar with people's histories and preferences. There was a complaints procedure in place and people told us they knew how to make a complaint if they needed to. Residents meetings had not been held recently but arrangements were in place to restart these on a monthly basis. People's views were also sought through an annual survey and a comments and suggestions box was available.

The service had been without key senior staff including the registered manager for a few months and another senior staff member was providing support to one of the provider's homes on a temporary basis during the inspection. This had affected the normal running of the service. There was a new manager in post who had identified most of the issues we found at the inspection, and, with senior staff at the service had a planned programme to address most but not all of the areas that we identified for improvement. The manager had clear goals of how they wished the service to develop. Staff were positive about the new manager who they said was approachable, visible in the home and open to any suggestions for improvement. There were systems to monitor the quality of the service and to identify issues that needed to be rectified which the manager had improved since being in post.

Summary of findings

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. We found the arrangements for the administration of covert medicines were not robust. Not all staff knew how to dispose of medicines safely. Medicines were safely stored and other medicines were safely administered

There were not always sufficient numbers of staff at meal times and we have made a recommendation about infection control measures and water temperatures.

People told us they felt safe and there were arrangements to deal with emergencies. Staff were aware of signs of abuse and what action they should take. Checks were carried out on equipment and the premises to reduce risk. Appropriate recruitment checks were in place.

Is the service effective?

Requires improvement

The service was not always effective. Staff had received training on the requirements of the Mental Capacity Act 2005 code of practice and Deprivation of Liberty Safeguards but people's capacity to consent to some specific decisions were not always assessed.

Staff received training in areas specific to the people they supported and told us they were well supported to carry out their roles. Supervision arrangements for some staff had not been consistent. The manager was working to address this.

People told us they enjoyed the food and that there was choice available. We saw that people's fluid and food intake was monitored and appropriate action taken if people lost weight. People had access to a wide range of healthcare services to ensure their day to day health needs were met.

Is the service caring?

Good

The service was caring. People told us their privacy and dignity was respected. Relationships between staff and people they gave care to were characterised with humour, patience and kindness.

Staff knew people well and were aware of changes in their moods or routines.

People and their relatives told us they were involved in making decisions about their day to day care.

Is the service responsive?

Requires improvement

The service was not always responsive. People's records were not always updated to ensure there was an accurate up to date record of their care. The new manager had identified this issue and was working to address it. Staff communicated well to ensure people's needs were met.

Summary of findings

Some improvement was needed to the level of activities and entertainment for people to participate in.

People knew how to complain and said they were confident any complaint would be looked into. An annual survey was organised by the provider.

Is the service well-led?

Requires improvement 

The service had not been consistently well led. We identified some breaches and some areas for improvement although most of these had been identified by the new manager and work had started to address these areas.

There were meetings with groups of staff to aid communication and to ensure consistency was maintained within the service. Staff felt the change in manager was bringing improvements to the service and that they were approachable and listened to their views.

There was a system of checks to monitor the quality of the service and these included checks by the provider. Some external audits had been carried out where there had been identified concerns such as infection control to reduce risk.

Northbourne Court

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 08 -10 April 2015 and was unannounced. There were two inspectors on the first day of the inspection and four on the second day. There was a specialist advisor for the first day of the inspection 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 service.

Before the inspection we looked at the information we held about the service including information from any notifications they had sent us. We also asked the local authority commissioning the service and safeguarding teams for their views of the service.

We spoke with thirty people who use the service, nine relatives, thirteen care staff, four team leaders, two domestic staff and the domestic manager, one activities organiser, three catering staff, the manager and two care managers at the home. Not everyone at the service was able to communicate their views to us so we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with two health professionals visiting the service.

We looked around the building. We looked at sixteen records of people who used the service, ten staff recruitment and training records and recruitment records for four volunteers. We also looked at records related to the management of the service such as staff rotas, audits and policies.

Requires improvement

Is the service safe?

Our findings

People told us they received their medicines on time. One person said "My tablets come promptly, and they do my eye drops for me." Most medicines were administered safely, and Medicines Administration records (MAR) were up-to-date and accurate. The systems for storing, administering and monitoring controlled drugs followed good practice guidelines. However arrangements for the administering of covert medicines were not always safe. For example pharmacist recommendations for one person for the safe administration of some medicines were not being followed so there was a risk they would not be effective as treatment. For another person there was no record of a recent mental capacity assessment, to confirm if they could make a decision about their medicines or relevant pharmacy advice or a care plan to say how the medicines should be administered and what to do if the person refused their medicnes. There was no evidence that the procedures for safe administration of covert medicines had been followed.

Some staff told us they disposed of medicines safely and in line with the provider's policy by collection from the pharmacy. However two members of staff told us they dissolved some drugs and put them down the sink or into clinical waste. This was contrary to the provider's medicines policy and not in line with National Institute of Excellence Guidelines 1.12.6 on the safe disposal of medicines.

Guidance for staff on when to offer as required (PRN) medicines was not always recorded in care plan's or in medicines records in line with NICE guidance. There were no risk assessments or plan in place to manage pain for two people with injuries. Staff may not therefore be aware of what action to take or when to give pain relief.

Arrangements for the appropriate and safe management of medicines were not always in place. People were not always protected from the risk of unsafe disposal of medicines and arrangements for the administration of some medicines were not always correctly followed.

There was a risk people were not always protected from the unsafe management of medicines. These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Medicines were stored securely. Room and fridge temperatures were monitored correctly to ensure medicines were stored safely and safe for use. We observed medicines being given to people on both floors of the home, and saw that staff took time to administer medicines to people in a caring manner without rushing. People were supported to self-administer medicines where this was appropriate. Checks on staff competency to administer medicines were regularly carried out and staff we spoke to were knowledgeable about how to administer medicines safely.

We received mixed views about staffing levels within the home. Some people told us there were staff available when they needed them. One person said "I don't wait long for the buzzer." However another person told us staff were always very busy and they did not like to bother them. A third commented "They do not have enough time to provide activities." A relative said "There's not enough staff, as some residents need two to help them, and that sometimes leaves only one." We found there were not enough staff available to meet people's needs at all times.

Staff views also varied, ten staff told us they thought more staff were needed; three identified meal times as problematic and three others said they did not have time for activities with people. Other staff said it was hard to meet people's needs at times and weekends were difficult as there was sometimes staff sickness and it was difficult to get replacement staff. Two staff members told us they thought there were enough staff and one team leader said "We can ask for extra staff according to people's needs." It was unclear when or how the original levels of staffing had been decided and staffing levels on the units did vary in the home. The manager and care manager told us people's dependency levels on some units had been looked at recently and gave examples of where they had increased staffing levels on both a temporary or permanent basis in recent months due to an increase in people's needs.

We found there were not enough suitably trained staff available on some units at meal times. The provider had additional serving staff during the lunch period on some units but the serving staff were unable to assist with people's care needs. Not all units had servers and where they were ill or on holiday there did not appear to be system to replace them. This meant people did not always receive support in a timely way. For example, on one unit we saw people did not receive their drinks until the end of

Requires improvement

Is the service safe?

the meal because staff were busy with other tasks. People who chose to eat in the lounge waited 50 minutes to be served. A staff member said "Those who need assistance with eating have to wait until the end of lunch as there are not enough of us today to do everything on time." Staff were patient and kind to people when serving lunch but they had difficulty assisting people in a timely way.

On another day in a unit where some people living with dementia were supported, staff left a hot trolley unsupervised for a few minutes in order to support people in their rooms which was a potential risk of injury. There were a number of people who required support to eat and only two staff members. We observed one staff member trying to support two people at the same time to eat and drink. Two people who needed encouragement to eat received very limited support from staff who were busy attending to everyone's needs. On another unit at lunchtime we observed that there were two care staff on duty that needed to assist several people with personal care who required support from two members of staff to mobilise. This meant there was no staff member in the lounge to provide reassurance or assist anyone else who wished to mobilise.

We found that the registered person had not protected people from the risk of insufficient numbers of suitably qualified staff being deployed to meet people's needs at all times. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Most people and their relatives told us they felt the home was clean. However two visitors told us that sometimes when they visited there could be an odour and that one toilet was not always cleaned promptly. One visitor said, "It is not always as clean as it could be." Two relative's commented they felt it had improved significantly in recent weeks. During the inspection we found the home was warm, communal areas, people's rooms and the kitchen were clean and tidy and free from any unpleasant odour.

There were some other areas for improvement and we saw the manager was working to address these issues. There had been a respiratory infection outbreak within the home earlier in the year and the provider had notified relevant agencies correctly and stopped admission during the outbreak. They had consulted with external agencies for guidance to reduce risk. Staff told us they had carried out a deep clean following the outbreak. The home had its own in house domestic team but there was no domestic staff working after 2pm each day. The responsibility for any cleaning required therefore fell to care staff after 2pm.

The manager had identified this issue and the need for more regular deep cleaning and was in the process of recruiting an additional domestic staff member to work in the afternoons. Cleaning schedules had been revised and daily cleaning reviews were undertaken by the domestic manager. The manager and domestic manager had identified areas for action which included better recording of cleaning carried out. Staff had access to protective equipment and this was used appropriately. Hand sanitizer were available throughout the home at entrance points and in dining areas. Cleaning materials were safely stored. Staff had a good understanding of hazard safety. However actions identified were not always being carried out. We found the cleaning audits on one unit had not always been completed. Some equipment stored in two sluice rooms were contaminated and some cleaning equipment, such as mop buckets, were dirty. Two of the care staff on the ground floor did not know where to find a spillage kit and were unclear of the procedure for cleaning up spillages. We raised this with the manager who agreed to address this during the inspection.

An external legionella risk assessment dated December 2013 had recommended some follow up actions for immediate attention and some requiring action within 3 months. The manager identified that some actions had been completed, but not recorded appropriately. There was an action to ensure staff training for those undertaking checks and the manager showed us this training had recently been booked for May 2015. The water temperature check record used by the provider had an incorrect temperature as a guide for staff, lower than that recommended in current guidance. Some of these checks showed a range of temperature fluctuations below and above those recommended which had not been recognised during internal and external checks according to the records. This could put people at risk from water associated infections developing.

We recommend the provider seeks further specialist advice in relation to the fluctuations in water temperatures and systems to detect water associated infections.

Requires improvement

Is the service safe?

People told us they felt safe and did not feel bullied or discriminated against. One person told us "Yes, yes, all safe and very good here." A second person said "It's very safe and all my things are safe here." Relatives told us they felt their family members were safe and well looked after. One relative told us "We needed (our family member) to be safe and now they are."

Staff were aware of the safeguarding policies and procedures and knew what action to take to protect people should they have any concerns. There had been twelve safeguarding alerts investigated since the beginning of January 2015, four were unsubstantiated, one had been substantiated and seven were being investigated at the time of the inspection. The home had worked in cooperation with the local authority in relation to safeguarding investigations and notifications to the Care Quality Commission and safeguarding authorities were appropriately made.

Risks to people were identified; for example risk of falls, health risks such as epilepsy, use of bed rails, skin integrity and nutritional risk and there was guidance for staff within the risk assessments. There had been an increase in the number of falls which had resulted in injuries earlier in the year. This increase had reduced in recent weeks. The manager showed us they were undertaking a detailed analysis of the causes of any falls to ensure anything to reduce risk to people was being considered. We saw where appropriate referrals were made to health professionals such as a rapid response team for advice to reduce the risk of people falling. A member of this team who visited the service during the inspection told us the staff at the home worked well with them and followed advice given.

Some improvement was required in the recording of some risks. Although we saw that regular checks were made on people in their rooms during the day and at night there were no current risk assessment records for those people who may not have capacity to use a call bell or where they had been removed due to possible risk. Staff told us they had previously been carried out but records were removed in a reorganisation of care plans. This meant that current risks to people with regard to call bells may not be readily identified.

There were plans to deal with a range of emergencies. Staff had received fire training and knew how to respond in the event of a fire. While evidence of regular fire drills during the past year was not available, the new manager had revised the emergency fire procedure and recent fire drills had been organised and included night staff. A system for regular fire drills had now been established. Personalised emergency evacuation plans for people were accessible in an emergency. Staff knew what to do in response to a medical emergency and fire and received first aid training.

Recruitment checks were undertaken before staff started work to reduce the risk of unsuitable staff. Staff files showed evidence that all required checks had been completed before people started work. There was a volunteer recruitment policy and checks were carried out including criminal record checks.

Checks were made on the premises to ensure any risks to people were identified and acted on. There was an up-to-date fire risk assessment and no concerns identified for action. The manager had identified some issues with previous monthly health and safety checks that did not record action taken in respect of any issues found and was addressing this, so there was now a clear log of actions and the date issues were resolved. We saw evidence of health and safety meetings where this was discussed and responsibilities for checks were re-organised and health and safety information was displayed for staff to improve their knowledge. The manager conducted regular walk around checks and recorded any issues noted with relevant action taken. They had identified that the frequency of some checks on aspects of the premises, such as fire doors were not previously carried out in line with the provider's policy and had taken action to resolve this.

Equipment was routinely serviced. Equipment at the home such as hoists, lift, gas installation and electrical equipment had been routinely serviced and maintained which helped reduce risks to people. The new manager had identified some previous issues with the record keeping in relation to service checking and the maintenance of equipment and was in the process of reorganising this so a clear audit trail was available and equipment was promptly repaired. We saw a record of a maintenance check on emergency lighting dated 8 July 2014 that advised of some failures in the system but there was no record that this had been addressed. The manager organised a check of this system during the inspection.

Requires improvement

Is the service effective?

Our findings

People told us that staff asked for their consent before they provided care and we observed this to be the case. For example staff checked that people gave consent to the support they offered in helping them mobilise or with personal care. In some circumstances best interests decisions had been taken in consultation with relatives and other relevant professionals for example about people's medicines or the use of bed rails to prevent injury and these were recorded.

However, people's capacity and rights to make decisions about their care and treatment were not always consistently assessed in line with Mental Capacity Act 2005 (MCA 2005). Care plans did not contain mental capacity assessments where people's capacity to consent to make decisions was in doubt. For example, seven care plans recorded that the person had dementia and lacked capacity to make some decisions about their care, for four of these people staff recorded they gave personal care in that person's best interests but there was no capacity assessment completed in relation to decisions about their personal care. People's care plans had a specific night time care plan and there was no evidence in eight of the care plans that people had consented to this plan or where they may lack capacity to make this decision a mental capacity assessment carried out and best interests decision reached.

However there were no recorded mental capacity assessments completed prior to the application for Deprivation of Liberty Safeguards (DoLs) authorisations to record an assessment that the person did not have capacity to make a decision about some aspects of their care. (These safeguards are considered where it might be necessary to restrict a person's freedom to protect them from harm where they are unable to make decisions for themselves.)

We found there was not always evidence that the provider had acted in line with the requirements of the Mental Capacity Act (2005) code of practice at all times. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Processes to follow DoLS authorisatiosn requirments were in place. A visiting professional and best interests assessor told us that they had visited the home several times and believed the staff were making the appropriate level of referrals for DoLS assessments. A care manager monitored all DoLS applications and authorisations to ensure that appropriate procedures were followed

People told us they thought the staff were suitably trained and skilled to carry out their roles. One person said "I have confidence in the staff here. They remind me about fire drills, and remember to check on me." Domestic, catering and care staff told us that they received sufficient training and support to carry out their role. One staff member told us "There is always lots of training going on and we get it refreshed." They told us that the managers encouraged them to develop. One staff member said "I have been given the opportunity to develop into a team leader role." The provider had an admiral nurse who offered support and guidance on dementia awareness to staff through regular training. New staff received an induction which included a period of supervised practice as well as training to provide new staff with sufficient knowledge and skills for their role. A range of mandatory training was provided as well as additional training such as end of life care and pressure area awareness. Staff told us they were supported and encouraged to undertake the Health and Social Care Diploma. The management team had identified that there were some missing training records to verify staff had completed training and action had been taken to address this. Mandatory training was mostly up to date except for refresher Health and Safety training for approximately half the staff and some safeguarding refresher training. Some training had been cancelled due to the infection out break but we saw new dates had been rebooked.

Some improvement were required to ensure all staff received regular supervision. Staff told us they received regular supervision and an annual appraisal to support them in their roles. However supervision records showed some inconsistency. For example of the sixteen night staff only one had received supervision in the last quarter. The manager had identified this issue prior to the inspection and an action plan was in place in which staff were expected to receive supervision before the end of April.

People were protected from the risk of malnutrition and dehydration. People's weight was monitored monthly or more frequently if required. Where there was a risk identified staff completed food and fluid charts and we saw these were checked by senior staff and referrals made to the GP if needed. Some people were on fortified diets to

Is the service effective?

help maintain their weight. One person said "you can go up and get drinks, but I don't worry. They bring tea here, or milk." A relative commented "Staff are very particular about them drinking fluids, especially when it's hot." We observed staff offered plenty of fluids and small snacks throughout the day. Food allergies were clearly detailed in people's care plans and these and people's dietary needs had been given to the kitchen staff to ensure people received the right kind of diet for any religious or cultural needs and in line with their preferences.

There was sufficient to eat and drink although we heard a range of comments about the food. One person told us "Eight out of ten for the food here! It's always hot, and there's a choice of two or three things." Another person said "It's very nice food. I eat it all up." Relatives were positive about the food; one relative told us "The standard of food has improved tremendously." Another relative said "The food is all good here. There is plenty to eat." However two people told us they thought the portion size was small. One person commented "I think there's enough, but some of the meals are not big portions. The food can be all the same, with not much variation." Two other people said they felt there was not enough choice in the range of sandwiches offered and another person wanted a greater range of vegetarian options and more fresh fruit available on each unit as this could run out and staff did not always replenish it. Kitchen staff told us they visited each unit to ask for feedback about the food and used this to inform their menu planning. We saw fruit was available on the units during the inspection.

People chose where they ate their meals and had a choice of food. Staff told us this was usually done the day before and people could forget what they had ordered, but they could then be provided with an alternative. The manager had highlighted this issue in an action plan and confirmed thatt this would be addressed. We saw people were offered more food when they had finished.

People had access to health care professionals. People told us they saw the doctor, dentist or chiropodist when they needed to. One person told us "I have seen a doctor here and they got my eyes tested because of my headaches." Another person said, "The doctor comes regularly. They are very good like that." Relatives we spoke with felt that people's health care needs were addressed. One relative told us "staff are very hot about getting a doctor for him." Another relative told us "The doctor, chiropodist and optician come regularly here, but I am not sure about the dentist." Staff told us that a practice nurse visited the home on a weekly basis and would come more often if needed and a GP visited. Staff arranged and took people to a local dentist as they said there was sometimes a wait for a community dental visit to the home.

Records were made by professionals of their visits and advice. These included the dentist, mental health team, GP, district nurse and members of the rapid response team. We spoke with two visiting health professionals who both said that the staff were very helpful and receptive to any advice and knew people well. One professional told us there had been some previous communication problems as staff had been busy when they visited, but these had been resolved as they now feedback to one of the care managers and this worked well. The care managers told us the information from this feedback was sent to each relevant unit and team leaders then added this to people's care records to make sure they were up to date.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring and kind. One person said, "The carers are almost perfect! The staff are what make it here. Mainly, they are all good." Another person commented "The staff are lovely here. They know what I like." Two people said that they found the agency staff were less helpful in manner and they did not know them well but told us "Some of the staff I really love, and they love me too." A relative told us "Staff are very kind and understanding, so caring, and they really like (my family member)." Another relative commented "The staff are all wonderful here, very cheerful and kind." Relatives told us they could visit whenever they wished to. One relative said "You can visit at absolutely any time, and I do! They are so welcoming." Another relative said "The kids are so welcome here, which is nice. There is space for them, and the staff know that all the people love to see the children. There are toys here too, so we are all welcome." There was a calm, friendly and pleasant atmosphere and we observed staff interacted positively with relatives.

Staff knew people well and demonstrated an understanding of people's life histories, routine and preferences in their conversations with them. They responded to people in a polite and respectful way and where some people showed signs of disorientation or discomfort staff supported people with reassurance and care. We saw meaningful communication, in which people were assisted at their own pace, without being rushed, for example, where people needed support to mobilise or re-position.

We observed that staff were able to detect changes in people's moods from their body language. They were active in their offers of help and checked people were happy with the support provided and chatted in a natural way to the people living at the service while they offered support and care. A relative told us how a staff member had volunteered to come in and help get their family member ready for a big family event. "That is above and beyond," they commented.

People told us they felt involved and consulted about their care needs. They chose when to get up and go to bed and where they wished to spend their time. One person commented in relation to staff "Whatever you want, they do!" We observed people made decisions about day to day activities and were given choices about what they would like to eat and their daily routine. Another person said "I like it quiet and they know that. I prefer it in my room and no one bothers me here."

Where appropriate people were encouraged or supported to make decisions. Staff told us they tried to ensure that people were involved in the reviews of their care although there was no formal process for this. People's personal care plans recorded the aspects of care that they could manage independently and those they needed some support with. One person told us "They learn what I can do for myself and I can be more independent. " Two people had discussed a preference to manage an aspect of their care independently and this was being respected and supported by staff. The home had links to an advocacy service staff could refer people to if needed.

People told us they were treated with dignity and respect. Staff were aware of the need for confidentiality and we observed them to speak discreetly with people about any health or personal issues. People were well presented and looked clean and comfortable. We observed staff knocked and asked if they could enter people's bedrooms, so that their privacy was respected. People confirmed staff were consistent in doing this. We observed staff being sensitive and discreet to people's individual care needs and routines throughout the day.

Requires improvement

Is the service responsive?

Our findings

People told us they received care that met their own individual needs. One person told us "I have everything I need here. The staff make sure of that." Another person commented "The staff help me to be as independent as I can." Each person had been involved in an assessment of their needs and had a care plan in place that detailed activities of daily living and the range of support they required. Staff knew people well and were able to describe how they met people's individual needs.

Overall relatives told us they found the staff responsive to people's needs. One relative told us "They calm him, they take him into the garden, and they are proactive, not at all regimented." Another relative commented "The staff seem to be adjusting to his deteriorating condition well." However two relatives told us that communication could be an issue as staff were very busy and therefore things were sometimes missed; for example if they wanted their family member ready to go out at a particular time. We found that aspects of the way people's care was recorded could be improved.

Staff were able to tell us about people's needs and how they responded to them. However people's care plans required improvement to accurately reflect all their current needs so that there was an accurate guide for staff to follow. Of the sixteen plans we looked at only four showed evidence of people or their relatives involvement in the plan or any changes to it. People's wishes for end of life care had not been recorded in six care plans we looked at. Reviews of people's care plans had not always been consistently completed in line with the provider's requirement for monthly reviews.

There were no separate care plans for skin integrity. However we observed staff knew the people at risk and reduced risk by using pressure relieving equipment and re-position and mobilise people with skin pressure areas and showed awareness of the risk to people. Tools to aid recording of skin concerns were not always used effectively. For example, body maps were used to record more than one concern or injury and did not track the progress of healing with the injury. This made it difficult to track if healing had occurred; other tools such as photographs to track wound progress were not in use. Risk assessments usually included identified support needs rather than these forming the start of a separate support plan and this meant it was difficult to check how effective this record was in providing support.

The new manager had put a plan in place to ensure care plan records were reviewed and up to date. The local authority commissioning report of March 2015 and the provider's own internal audits had identified that the care plan records were not up to date in January and February 2015. The new manager had identified many of the issues we found and was working with the team leaders and senior staff to address the care plans. They had recently organised for staff to be given additional working time to update the care plans so that people had an accurate record of their care. We were told the provider was also reviewing the care plan documents to make them easier for staff to read. A new care plan audit tool was being introduced which staff said would make it easier and quicker to audit care plans.

Staff communication about people's needs through handovers at the start of each shift was effective. We saw handover records included a summary for staff on changes to people's care and action taken to respond to changes in people's needs. Each staff member was given a copy of this summary as they started their shift so they had an up to date guide of people's needs.

People's need for stimulation and social interaction was not always addressed. However, we saw the manager had identified the need to develop the level of activities within his action plan and told us this was in progress. Some people preferred to spend time in their room and not engage in any organised activities other people told us there was not always a lot to do. One person said "There's not much to do, but its fine. We sit outside when it's nice." A relative commented "There are some activities, but not much." People's care plans identified people's preferred activities but it was not always clear how these were met. While there were some organised activities for small groups in progress on two days of the inspection, we observed that people were in the lounges on each unit unoccupied for much of the morning and afternoon. There were activity schedules posted in people's rooms but on several units these were out of date.

There were three activities organisers at the service who did not work full time. An organiser told us this meant they tried to do one activity in each suite a day, although this

Requires improvement

Is the service responsive?

was not always possible as they needed to plan for other activities. They arranged small outings for example to a local dementia café or garden centre or in the summer to the coast. They also tried to spend some individual activity time with people and had a list of people's preferred activities to refer to. They told us it was difficult to manage this with the staffing they had; some care staff tried to be involved but they were also very busy. They said they were encouraged by the new manager who was interested in developing the activities and they had discussed improvement ideas with them. Each unit now had an activities box that care staff could use when they had the opportunity and the manager had suggested the sourcing of appropriate contents for staff to use to encourage interaction that was more meaningful to people.

There was a "Piazza" coffee area at the home which was used for outside entertainment and was intended to be available for visitors to meet with family members. This was not always in use during the inspection. The manager told us they had needed to recruit a new member of staff for this area and had started to review its use with the key groups of people who make use of it to ensure it was used to maximum potential. The home had links with local schools that visited occasionally to sing and invited people at the home to appropriate school events.

People's links with the community was encouraged where possible and people who were able and chose to spend some time in the community were supported to do this. Some people attended a local church hall coffee morning.

People told us they knew how to make a complaint if they needed to. A relative told us they had made a verbal complaint about cleanliness of a room and it had been acted upon. The manager told us the provider's complaint policy was usually on display in the entrance but had been temporarily removed as they were decorating this area during the inspection. We saw there was a comments and suggestions book in reception and the last entry was undated but was complimentary about the home. We looked at the complaints log and saw there had been two complaints and a compliment since September 2014. These had been responded to by the service.

People told us they had attended residents meetings on each suite although there were no records of any held since October 2014. We saw at these meetings topics such as food and drink, activities and entertainment were discussed. We were not able to find any evidence that people had been consulted about the redecoration of the home which had been organised prior to the arrival of the new manager. The manager told us now the infection out break had finished the residents meetings would be restarted and held on a monthly basis on each unit. They had also planned an initial introduction meeting to relatives later in the month.

The provider organised an annual survey conducted by an independent body to see the views of people who used the service. We were shown the results of the 2014 survey in which the service was rated across a number of main areas overall satisfaction had gone down slightly by 3% from last year; with areas of food choice and quality being identified as showing among the least satisfaction in results and quality of life as the highest.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection a new manager was in post and was submitting an application to register with the CQC. People and their relatives told us they thought Northbourne Court was run well and staff were clear about their roles. They were aware there was a new manager but not everyone had met them. The manager told us that due to the infection out break it had not been possible to meet everyone living at the home as soon as they would have liked. An introductory meeting for families was planned for May 2015.

The service had been without some key senior staff including the registered manager for several months. Another senior staff member was providing support to one of the provider's home's on a temporary basis during the inspection. We found this had affected the running of the service, for example the completion of care plan reviews to ensure they were up to date, delay with staff supervision and absence of records of residents meetings. Some internal audits to track the quality of the care had not always been regularly completed in this period. However since the new manager arrived audits had been completed across different areas of the service including infection control, care plans, health and safety, and the manager had completed some spot checks on food quality. It was too early to judge the effectiveness of these measures.

The provider also carried out their own audits across the service; most recently these had included a care plan audit and an infection control audit on 01 April 2015 in which it was identified that staff were not always recording the temperature of the food served in the units. The provider had taken action to address this. We saw at the inspection staff had a probe to test food temperature on each unit and record the result. The provider had also requested the advice of the environmental health team to ensure they were doing all they could to reduce the risk of infection.

Incident and accidents were recorded and included details of actions taken and outcomes to identify learning for the service to reduce reoccurrence. These were being analysed at the time of the inspection to ensure that any actions to reduce the risk of falls were identified and addressed. Falls prevention training for staff had been organised. Records of incidents and accidents demonstrated that notifications to the Care Quality Commission and safeguarding authorities were appropriately made. Staff from the home had met regularly with health professionals from the Clinical Commissioning Group to review hospital admissions and any other identified themes. We saw minutes of these meetings where arrangements to meet people's health care needs were discussed.

Staff in various roles within the home were positive about the new manager. They told us they had noticed a number of changes since they had arrived for example there was a greater emphasis on activities for people. They described them as "Very approachable" and "They makes things happen." One staff member said "You can really speak to them and they do listen to your ideas." Another staff member commented "I really feel they want to make sure everything runs well here." Staff felt they were visible within the home and was working to make changes for the better across the service. Staff also felt supported by the rest of the management team and described them as good listeners and "always available if you are having any problems and "they help sort things out."

The new manager had clear goals of wanting to improve the quality of the home so that it was more effective in the delivery of person centred care and encouraged greater involvement with people and respect of their individuality. They had started to use staff appraisal systems to improve the quality of staff communication with people for all staff across the service. This included staff receiving regular individual development sessions. The home had planned to start work with a local hospice on a recognised programme for end of life care.

The manager had an action plan across a number of areas to correct issues they had identified including most of those found at the inspection. During our visit we saw that action plans were being followed with some identified issues resolved. For example, the storing and organisation of records and provision of activity boxes on each unit and some health and safety issues. Some tasks and responsibilities around the service had been re-organised to ensure completion and records amended to track action taken. There was a system of daily briefs with managers across the service and a management weekly team meeting to track progress.

Staff were kept updated about people's needs to minimise risk and improve consistency of care. There were hand over meetings between shifts to share any immediate changes on a daily basis to ensure continuity of care. There had not been a regular full staff meeting since the departure of the

Requires improvement

Is the service well-led?

previous manager but one was planned for the following month. We found information for people and staff was in the process of being displayed on notice boards

throughout the service to provide people and staff with relevant information about the service. Staff told us they worked well as a team and supported each other to try and provide good care. Our observations confirmed this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(g) HSCA 2008 (Regulated Activities) Regulations 2014** Medicines Arrangements for the proper and safe management of medicines were not always in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(1) HSCA 2008 (Regulated Activities) Regulations 2014** Staffing Sufficient number of suitably qualified and experienced staff were not deployed throughout the day.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).** Need for Consent Arrangements to follow the Mental Capacity Act were not always correctly followed**.**