Akari Care Limited

Pavilion 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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection was carried out over three days on 7, 8 and 15 January 2015. The first visit was unannounced. The home was last inspected in September 2014, when we found breaches of seven regulations regarding meeting nutritional needs; safeguarding people from abuse; staffing; supporting workers; assessing and monitoring the quality of service provision; notification of incidents; and records.

Pavilion Court is a care home which provides accommodation and personal or nursing care for up to 75 older people, some of whom are living with dementia. There are four separate units, two of which accommodate people with general nursing and residential care needs; and two which accommodate people who have nursing care needs and are living with dementia. There were 51 people living in the home at the time of this inspection.

The home did not have a registered manager in post at the time of our inspection. The previous registered manager resigned in November 2014. 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

Summary of findings

and associated Regulations about how the service is run. An acting manager was in post. This person told us they were in the process of applying to be registered with the Commission.

Systems for recognising and reporting abuse or suspected abuse had improved. Staff were clear about their own personal responsibility to report any incidents of potential or actual abuse immediately. The acting manager had reported four such incidents to the appropriate authorities since our last inspection. People told us they felt safe in the home, and knew how to report any concerns they had.

The ratio of staff members to people in the home had increased since the last inspection and we saw people were kept safe from harm as a result. The suitability of new staff was carefully checked before they started work in the home. Six new staff had been recruited, to minimise the need to use agency staff and improve consistency of care.

Most areas of the storage, administration, recording and disposal of people's prescribed medicines were safe. Some improvements were needed in regard to the management of some medicines.

People's needs were assessed before they started living in the home, to ensure all those needs could be met. People were involved in their initial assessments and their wishes and preferences about their care were recorded. A care plan was drawn up to meet each identified need, and these plans were regularly reviewed to make sure they remained up to date and relevant to the person's needs.

People were able to access the full range of community and specialist health services, and their health was routinely monitored by staff. Healthcare professionals told us they received appropriate and timely referrals from the service, and staff followed their advice.

Staff were kind and caring in their interactions with people, and we saw many instances of sensitive and person-centred care. Most people we spoke with were happy with their care and felt their needs were met. Staff were respectful and ensured that people's comfort and dignity was maintained. We also found that, at times (particularly mealtimes), people's care was not delivered in an organised and personalised manner, and that some staff lacked the skills necessary to meet the needs of people living with dementia. Health professionals told us the knowledge and skills of the staff team were variable.

A full staff training programme was in place, but staff were not being given the support they needed to carry out their duties, as they had not received appropriate supervision or appraisal of their work.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. We saw the acting manager had submitted appropriate applications to the local authority for authorisation to place restrictions on certain people's movement, in their best interests.

People told us they knew how to make a complaint. Concerns and complaints were responded to in a professional manner.

An enthusiastic activities co-ordinator organised a range of group activities and had good knowledge of individuals' social preferences, hobbies and interests. However, this information was not always shared with the whole staff group which meant there was not a team approach to meeting people's social care needs. Some people told us their social care needs were being met.

We noted an improved atmosphere in the home since the previous inspection and a clearer sense of direction. However, we found that there was a lack of cohesion in the staff team, and that roles and responsibilities were still not always clearly understood.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to safety, availability and suitability of equipment; and maintaining appropriate standards of cleanliness and hygiene. You can see what action we told the provider to take at the back of the full version of this report.

The breach in relation to supporting workers was ongoing. This is being followed up and we will report on any action when it is complete.

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?

Not all aspects of the service were safe. People were placed at risk because emergency alarm calls were not available in some bedrooms. Some parts of the home were not clean.

Staff knew how to recognise and report abuse or concerns.

Staffing levels had increased and people were kept safe as a result. Systems were in place to make sure any new staff were suitable to work with vulnerable people. Some elements of medicines recording required improvement.

Requires Improvement

Is the service effective?

Not all aspects of the service were effective. Staff had not been given the necessary support, in the form of formal supervision and appraisal of their work. Although a comprehensive training programme had been put in place, some staff lacked the skills and knowledge to meet people's needs.

Systems were in place to assess and meet people's health and dietary needs.

People's rights were protected under the Mental Capacity Act 2005 and no one was being unlawfully deprived of their liberty.

Requires Improvement

Is the service caring?

Not all aspects of the service were caring. Although staff displayed a genuinely caring approach, the dignity and independence of some of the more vulnerable people were sometimes compromised by some organisational practices, such as poorly planned meal times.

People were not supported to express their opinions about the care and the running of the home because systems to gather their views had lapsed.

Staff were knowledgeable about the support people required and respectful in their manner.

Requires Improvement

Is the service responsive?

Not all areas of the service were responsive. People told us staff did not always make time to talk with them, and felt there were not enough social activities to engage them.

People's needs were fully assessed and care plans were in place to meet those needs.

People told us they knew how to make a complaint, and felt they would be listened to if they raised concerns.

Requires Improvement

Summary of findings

Is the service well-led?

The service was not always well-led. However, a new manager was providing leadership and making significant improvements to the management of the home. It was too soon to be confident that all the changes necessary for the service to be judged as 'well-led' had been made.

The culture in the home had become more positive and inclusive and the quality of care had improved.

Systems for involving and supporting staff and for working jointly with other professionals were being introduced.

Requires Improvement

Pavilion 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 7, 8 and 15 January 2015 and it was unannounced.

This inspection was carried out by one adult social care inspector; one inspection manager; a specialist adviser in the field of dementia care; 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.

Before the inspection we reviewed the information we held about the home. We reviewed the notifications of significant incidents the provider had sent us since the last inspection. We contacted local commissioners of the service, Healthwatch, GPs and other professionals who supported some of the people who lived in the home to obtain their views about the delivery of care. These included nurses specialising in infection control, tissue viability and continence issues; a consultant psycho-geriatrician; a member of the challenging behaviour team; a dentist; a pharmacist; an optician; a speech and language therapist; a GP; a district nurse; and a member of the NHS Specialist Care Homes Support team. We have included their views in this report.

Before the inspection we had requested the provider sent us a Provider Information Return. This is a form in which we ask the provider to give some key information about the service, what the service does well and what improvements they plan to make. This request was not received by the service, but the acting manager was able to complete and return this information in the course of the inspection.

During the inspection we spoke with 12 people who lived at the home, four visitors, three senior care staff, seven care workers, four ancillary staff, two nurses and the acting manager. A large proportion of people were unable to communicate with us verbally because of the nature of their condition, but where we could speak with people we have included their comments in this report. We observed care and support in communal areas, using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records of eleven people. We also looked at records related to the management and operation of the service.

Is the service safe?

Our findings

At our inspection in September 2014 we were concerned that the systems for safeguarding people from abuse were not working. We told the provider they were in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We deemed this to have a major impact on people and took enforcement action against the provider. We wrote to them highlighting areas they must improve.

At this inspection we found improvements in respect of safeguarding people who used the service from abuse. We saw that four recent safeguarding issues had been correctly identified, recorded and notified to the local authority safeguarding adults team and to the Commission. We saw improvements in the response by management when staff raised concerns. Issues raised were fully recorded and investigated by the acting manager.

However, despite improvements in safeguarding processes, we identified concerns about people's safety in other areas. We saw that, in ten people's bedrooms, there were no nurse alarm call leads in place. In two of those bedrooms the alarm call leads were found in the chests of drawers in the room. In the other eight bedrooms, there were no alarm call leads. This meant people would be unable to use the home's system for summoning help in an emergency. We raised this issue with the acting manager, who told us they had been unaware of this issue, and took action to replace the alarm call leads before we left the building.

All the people we spoke with said they felt safe in the home, and most people said staff acted appropriately if they raised any concerns. We asked if staff came quickly when called. Some people spoke of delays, with comments such as, "At times they are a bit pushed. You ring; they come, and say 'five or ten minutes'. They are busy" and, "They come as quickly as they can. There are times when they are on other duties."

At our inspection in September 2014 we were concerned that the staffing levels were not sufficient to meet people's needs. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we asked the acting manager how staffing levels in the home were calculated. They told us they used a recognised dependency rating tool to work out the number of staff hours needed to meet people's needs safely. The acting manager showed us records that demonstrated the home was being staffed in excess of these basic levels. We noted the number of staff hours currently allocated was similar to the number used at the time of the last inspection, but there were now 12 less people living at the home. The acting manager told us the provider had recently employed six new staff, four of whom had taken up post, to reduce the need to use agency staff. We concluded there were enough staff available to keep people safe.

Staff recruitment records showed that robust systems were in place to ensure no unsuitable persons were employed to work with people in the home. We saw documentation including fully completed application forms, full work histories, proof of identity, written references from previous employers and evidence of checks of any criminal convictions, which satisfied us the provider's recruitment process was thorough and safe.

Visiting professionals told us they had no concerns for the safety of people living in the home. A specialist nurse said, "I'd say it was safe." However, a GP told us they had some concerns about cleanliness in the home, and gave examples of poorly cleaned bedrooms and a wheelchair which had "crusts of dirt" on it over at least a week. The GP told us, "This is an infection control risk."

We found some areas which were unacceptably dirty on the first floor. These included people's own armchairs within their bedrooms where large amounts of food debris and dirt and dust had accumulated beneath the chair cushions. We showed these to the housekeeper who acknowledged our concerns but was unable to say why these areas had been missed.

We spent time with the housekeeper who led a team of five domestics. She told us that more cleaning and laundry staff would be useful but added that daily numbers were currently reduced due to leave. The housekeeper also acknowledged that the lack of audit and oversight of what domestic staff were doing had led to some shortfalls in cleaning certain areas. The acting manager told us they were aware of some problems with cleanliness and had introduced a cleaning schedule to address the issues.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service safe?

The home had a contingency plan in place in case of emergencies, such as services failures or the home being rendered unusable through, for example, a major fire.

Both general risks in the home and specific risks to individuals were assessed on a regular basis, and actions taken to minimise such risks to people's safety. For example, we saw a person had been assessed as being at risk of weight loss. Appropriate actions were taken, including a weight-gaining care plan, and the risks were re-assessed monthly. We observed that moving and handling techniques used to help people with limited mobility were safe and in accordance with current best practice. Accidents were reported and recorded in detail.

One unit in the home was undergoing a major refurbishment at the time of this inspection. A suitable risk assessment was in place and available for staff to refer to in relation to the refurbishment work, which involved teams of contractors being on site. The housekeeper told us they were unaware of these but we saw comprehensive guidance and suitable checklists were in place. The acting manager and full time maintenance man were aware of the safety checks that were needed.

We found that some bedroom doors on the newly refurbished area on the first floor were not closing properly which could pose a fire safety risk. The maintenance person dealt with these immediately and the acting manager undertook to inform all staff of their joint responsibilities in monitoring and reporting any safety risks straightaway. We also found some areas, particularly the first floor room used as a dining room during the refurbishment, to be cramped and cluttered to restrict movement. This posed a potential safety hazard if there was an emergency during a meal time. This was discussed with the acting manager, who made immediate arrangements for a larger room to be used for meals.

We found systems were in place for the ordering, storage, administration and disposal of medicines. We looked at the medicine administration records (MARs) of 33 people. All MARs were fully completed, showing the administration of each person's medicines. However, we found 14 examples of new and short-course prescriptions having been transcribed by nursing or senior staff onto the MAR without the full signature of two members of staff. This is a safety check to ensure the correct information has been transcribed. We also found that two people's MARs did not have their photograph attached the MAR. This increased the risks of medicines being given to the wrong person. We recommend that the provider refers to the NICE medicines practice guidelines.

Is the service effective?

Our findings

At our inspection in September 2014 we were concerned that staff had not been provided with adequate formal supervision and appraisal of their performance. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found no progress had been made in this area. No staff members had received personal supervision or appraisal since the last inspection. One of the ancillary team, for example, told us, "There have been no supervisions for several months since I can't remember when". She also advised that she had received no 121 supervision for at least a year which we confirmed from her personal records. A member of the NHS specialist care home support team described an ongoing need to support the nurses with clinical and complex issues such as wound care and stated, "I don't know about the nurse's clinical supervision and whether they are receiving this". Records showed that the nurses had not received this formal clinical support or mentorship and that any form of supervision they had received over the past two years had not been personal to them, pertinent or helpful to their clinical roles and responsibilities.

The acting manager told us they had not had the opportunity to provide such support to staff since taking up post in October 2014; their priority had been the needs of people living in the home. The acting manager said they planned to delegate supervision to the senior staff member in each area of the service, and had communicated this to heads of the care, catering and housekeeping teams. They added that these staff were to be given the training necessary to perform this role in February 2015.

This was an ongoing breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked five people if they felt staff met their needs effectively. All five said their needs were met. Comments included, "I think they are a good help"; "If I ask, it's there"; and, "Yes, I get a shower every morning. They take me to the toilet and hang my clothes straight up if I've been out." We asked if staff had the right skills to look after them. People's comments were mostly positive. One said, "I think so"; a second person said, "I should imagine so, yes"; another told us, "Yes, most of them." However, one person told us it varied, and that only certain staff had the necessary skills. A second commented, "I don't like agency workers. They don't have the skills and knowledge like the permanent staff have."

At our inspection in September 2014 we were concerned that staff had not been provided with the training necessary for them to carry out their duties effectively. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found a training plan for the full year had been drawn up, appropriate training booked, and training started. Areas covered by the planned training included challenging behaviour, nutrition, safeguarding, mental capacity, deprivation of liberty, and dementia care.

At our inspection in September 2014 we were concerned that people were not always being given the support they needed to ensure they received adequate nutritional intake. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found improvements had been made. We saw that a white board had been fitted in the kitchen which recorded information about people's dietary needs including, for example, those requiring diabetic, soft- or low-fat diets, and those people who needed their meals fortified to help increase their weight. The chef told us he was now routinely given copies of people's dietary notification forms which, he said, had "helped massively" in meeting their food and drink needs and preferences. He said he now visited each unit weekly to speak to people about their meals and to check whether there were any nutritional issues with people's health and diet. The chef told us he was meeting with a nutritionist later in the month to help him revise and improve the food menus.

Care records showed that people's dietary needs were regularly assessed and advice was taken from nutritionists, where appropriate. People's food and drink intakes were recorded daily, where necessary to ensure an adequate intake. All but two of the people we spoke with said the food was acceptable, and most felt it was good (one person gave the food "Ten out of ten"). Other comments included, "The food is very good, you get what you want, there is too much"; and "It's alright." Only one person told us they felt the food was of a poor quality.

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Is the service effective?

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We asked visiting professionals whether they felt staff had the necessary skills and knowledge to meet people’s needs effectively. The views of professionals were mixed. A GP told us, “The staff need to improve their knowledge, generally.” The GP gave an example of having been called to attend to one person’s particular health need, but found the person also had symptoms of a chest infection that staff had not recognised. A consultant commented, “I find the skills and knowledge of the staff to be variable, and not always good.” This professional told us they had concerns about the communication between the home and primary and secondary health care services; that care records were not always made available; and that staff could not always give a good account of the person’s needs and symptoms. A specialist nurse told us some nurses and senior staff lacked confidence and understanding, and that care staff did not always follow advice given in the care plans.

Other professionals reported more positive experiences recently. An optician told us that, at a recent meeting, the acting manager had agreed to set up training in sensory deprivation for staff later in the month. A specialist nurse told us the acting manager had arranged for her to give infection control training to staff in the month of this inspection.

We saw people’s routine health care needs were documented and regular appointments made for them to see opticians, dentists, podiatrists, and other community health services.

Where there were concerns about a person’s ability to make informed decisions about any significant aspect of their care, a formal assessment of their mental capacity was undertaken. If it was confirmed the person lacked the capacity to make a decision such as agreeing to enter the home or to consent to taking prescribed medicines, a communal decision was made for them, in their best interests. We saw such mental capacity assessments and best interests decisions were completed appropriately by a staff member qualified to do so. We noted, however, that these processes were normally completed by a single member of staff, when the provider’s own policy indicated two staff should make a joint assessment and decision. The acting manager said she was auditing these documents and countersigning them, if she felt they were accurate. A member of the NHS specialist care home support team confirmed that everyone whose mental capacity required assessment had been reviewed and best interests decisions taken and implemented where necessary. We also saw that sensitive and appropriate decisions had been reached and recorded in relation to people where cardiopulmonary resuscitation (CPR) was not to be attempted should they stop breathing.

The acting manager told they were aware of the service’s responsibility to ensure no person was deprived of their liberty unlawfully. They were able to demonstrate they had acted appropriately in line with the law in regard to the Deprivation of Liberty Safeguards (DoLS). These safeguards are part of the Mental Capacity Act 2005. They are a legal process followed to ensure that people are looked after in a way that does not inappropriately restrict their freedom. Six applications had been submitted to the local authority for authorisation to place restrictions on certain people’s movement, in their best interests.

Is the service caring?

Our findings

Our findings

Most people we spoke with told us they were happy with the care they received. They said the staff were kind and caring to them, and some mentioned certain staff members as being particularly sensitive and attentive. One person told us, "I had an accident a couple of times, and I kept saying sorry, but they [the staff] were lovely. They said not to worry and they are very good at sorting me out." A second person said, "I think that they are very good with me – they do little things like changing the water in my flowers." Other comments included, "They treat me nicely", and, "I enjoy living here."

We spoke briefly with the family of someone who was very ill. They told us they had everything they needed, were kept fully up to date and were "more than happy" with the care their relative was receiving. A visiting specialist nurse told us about their observations of how the staff team provided high quality, person centred end of life care.

A visiting professional told us, "There's a lot of really helpful staff, who care for their residents. Lots of good carers." A member of the 'challenging behaviour' team commented, "The staff appear caring and considerate. They seem to want the best for their clients." A specialist nurse told us, "The staff are lovely." A second specialist nurse told us, "There is an increased calmness overall. More people are spending quality time in the day rooms, rather than being isolated in their bedrooms."

Positive new initiatives were underway where proactive weekly GPs rounds took place for around half of the people who used the service. This meant that any health issues were identified and dealt with quickly and people using the service could plan for seeing their doctor. One person told us, "I have a problem with my ear and I know the doctor is due this afternoon. I have a list of things to talk to him about".

We saw examples of good care practices in the home. Staff interactions with people were often very good. Staff were respectful, caring in their approach and we observed they spoke to people in ways that maintained their dignity. Staff ensured that people's comfort and dignity was also maintained when being moved or transferred. People we asked confirmed this. One person said, "Yes, they close the door or go outside or sit in my room and wait." The exchanges we heard between staff and people demonstrated staff had a clear understanding of people's needs. Our conversations with staff confirmed they were knowledgeable about people's personalities and preferences. For example, staff described how a person with sensory deprivation enjoyed having hand massages, and other tactile stimulation such as stroking fabrics.

Care staff involved people in activities in different areas at different times. We saw, in one dining room, people engaged in art work. One person who played the organ was being encouraged to entertain others in the room. The atmosphere was relaxed. Staff interacted with people well and people appeared to enjoy this experience.

However, we also observed some examples of practice that did not fully support people's dignity. At times, particularly after breakfast and during lunch, we noted staff seemed to be struggling to meet people's needs. For example, after breakfast, one person was sitting in the dining room in night attire, but without socks or slippers. We saw two people in their bedrooms had stained clothing, with food debris on them. We saw, in one lounge, that although staff were kind, attentive and caring, some did not have the skills to engage people who were unable to communicate verbally and were sitting in a withdrawn state.

As part of our checks on premises we found that some people's armchairs within their bedrooms had not been cleaned and harboured debris and dirt beneath the chair cushions. These people were living with dementia, were unable to speak with us, and needed the care and domestic staff to support them and maintain their wellbeing and dignity. We shared our findings with the housekeeper and acting manager who took immediate steps to address these findings.

Is the service responsive?

Our findings

People told us staff tried to be responsive to their needs. They said staff normally came promptly when needed and met their care needs. However, five people on the general nursing units told us staff did not sit with them and talk. One person told us, "They are too busy to talk." Another person said, "They don't have time." Other people's comments included, "They are all very nice, but they don't always have time to sit and chat. They come in, then the buzzer goes and they have to leave", and, "Not really [get to talk], very rarely. But if I needed to, I suppose they would." However, some people identified there had been some recent improvements, in that they were being encouraged to spend more time socialising in the unit lounges, where they had more contact with both staff and other people. The acting manager told us that, when the present refurbishment programme was completed in April 2015, the home was to be re-organised from four to two units, to allow for more flexible use of staff, and give staff more time to spend with people.

Before a person was admitted to the home, their needs were assessed by the professional making the referral to the home. Areas covered by these assessments included the person's behaviour, cognition, psychological needs, communication skills, mobility, nutritional and continence needs. Referrals from social workers were accompanied by a detailed risk assessment and a support plan.

An assessment of the person's needs was also carried out by the acting manager, to confirm the home could meet all the person's needs. This assessment focussed on activities of daily living, such as maintaining safety, personal care and hygiene needs, and the person's social and leisure needs. Their personal preferences about how their care should be given, and how they wished to spend their day, were recorded. These included their wishes food and drinks needs/preferences, their night time routines; and their directions about their future care, such as hospital admissions and wishes regarding resuscitation.

Written care plans were drawn up to guide staff on how to meet people's assessed needs and their expressed preferences about their care. We looked at eleven people's care records and saw many examples of detailed and person-centred care plans that reflected the person's identified needs and stated preferences, and gave appropriate guidance to care staff about their care. A small number of care plans were more prescriptive, and lacked any emphasis on issues such as promoting people's dignity and self-respect. Care plans were evaluated monthly and updated in response to people's changing needs.

The home had the support of a wide range of health professionals, including GPs, district nurses; specialist nurses in infection control, tissue viability, and continence; and specialist teams such as the 'challenging behaviour' team. Particular support and guidance was provided by the NHS nursing home support team, whose role is to work with homes to prevent unnecessary admissions to hospital. A visiting specialist nurse told us, "Individual emergency health care plans are being prepared and will be place for everyone." This meant that these could be used for urgent hospital admissions and that communications between health and care professionals would be up to date.

One person told us, "We have had a battle to get our flu jabs". We explored this with the acting manager and found that this was an issue beyond the control of the staff at the home. The acting manager confirmed that people were now receiving their 'jabs', albeit belatedly.

All the visiting professionals we spoke with said the home staff made appropriate and timely referrals to them, and recorded and followed the advice given to them by professionals. One professional told us, "The staff respond to guidance and ask for advice. They look for help." A specialist nurse told us, "They have been extremely receptive to advice." One specialist nurse told us there had been problems with some staff not reading or following advice in care plans, but noted recent improvements in this area.

A GP told us, "I have no immediate concerns regarding the care of patients. They are reasonably well looked after, on the whole. The staff follow my guidance." A nurse specialist told us, "There have been improvements. The staff have listened and acted, lately. Issues are responded to when pointed out." Another professional commented, "The established staff are OK; messages get passed on and there's continuity. But there seems to be a lot of agency staff used and this affects the consistency of care."

People told us they had choices about when to get up and retire to bed, what they wore, their activities and meals. Comments included, "Well I don't like everything on the menu– but they always try and fix me up with something else"; and, "Yes, you get choices. If I don't like what's on the

Is the service responsive?

menu I will ask for a sandwich." As part of the assessment of people's needs, we saw they were asked if they wished to be checked during the night and if they wished their door to be locked at night. They were given the option of using a 'do not disturb' notice for their bedroom door. This showed that people were given choices and staff responded to their wishes for personalised care and support.

We spoke with the activities co-ordinator, who demonstrated they worked hard to involve people in the life of the home, and to increase their well-being. As well as organising a range of group activities, such as arts, crafts, games, baking and reminiscence, the co-ordinator told us they spent as much time as possible getting to know people as individuals and recording their individual hobbies and interests, past and present. The co-ordinator employed imaginative approaches to meeting those individual needs in a person-centred way. We were given the example of a person with dementia who was very withdrawn and unable to communicate. Knowing the person used to play a musical instrument, the co-ordinator played them music tapes featuring that instrument, and managed to engage the person much more fully than previously. We were told poetry and bible readings had proved very popular and stimulating with other individuals, and had clearly enhanced their well-being. Other people enjoyed individual 'pampering' sessions.

Assessments were also carried out by staff of people's social care needs and preferences, but this information, and the good information collected by the activities co-ordinator, did not always result in a social needs care plan being drawn up. This meant other staff did not have all the knowledge they needed to treat people in a person-centred manner. We asked people what activities were available to them. Few were able to describe the activities. One person told us, "There's not a lot." A second person said, "Sometimes they have singers." A third person commented, "I don't know. I just sit here."

People we spoke with told us they knew how to make a complaint. Most said they would speak to a senior member of staff. The acting manager told us the service had received four complaints since our last inspection in September 2014. Areas of complaint included staffing, cleanliness of the home, communication issues and falls. We saw these had been fully investigated and that detailed written responses had been made by the acting manager. Three complaints had been partially upheld: one was not upheld.

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager in place. Our records showed the previous manager had resigned in November 2014. The acting manager told us she intended to apply to be registered with the Commission as manager of the home.

We asked six people if they felt the home was well-managed. All but one person told us they thought it was, currently. Comments included, "It seems to be", and, "At the moment it is – it seems OK." People told us most staff seemed happy in their work, and that the atmosphere in the home was good. People told us that the acting manager was approachable and that opportunities to provide feedback on the service and the care they received had increased. They felt confident to tell us about problems which they had experienced for example, "Our food preference information has been lost in transit when we moved room", "I have some difficulty with certain staff who I can't understand", and, "I haven't been asked for feedback". The acting manager knew about some of the issues raised with us and was keen to pursue all issues as quickly as possible.

Relatives were positive overall and felt that the atmosphere at the service was much more relaxed than it had been previously and that staff were better motivated. Again they felt able to share their current experiences with us. One relative told us the home had improved since the last inspection in September 2014. They said the current acting manager was bringing about changes, and that staff seemed to feel more valued. However, this relative felt the management and supervision of care at unit level was still not positive enough to promote good practice that met people's individual needs. Other comments from relatives included, "We have not been asked for any formal feedback or to complete a survey for well over a year", "We know there have been changes and about the last inspection report", "I know there have been some major concerns", and, "There was a meeting to tell us the manager had gone."

We saw this meeting had taken place in mid-November 2014 when attendance had been low. Other meeting dates were scheduled for the near future.

The acting manager fed back that surveys and satisfaction surveys were long overdue for people using the service, their relatives, staff and visiting professionals. Also, that take up and feedback had been low when these were previously undertaken. She was able to describe a new provider initiative where new style surveys were to be piloted by the end of January 2015 which would be sent directly to individuals for them to return to the provider. This showed the acting manager had recognised shortfalls in this area and sought to address them.

Most of the visiting professionals we spoke with said their visits were facilitated by staff and ran smoothly. One felt the home could be "a bit disorganised", but said this didn't affect the care. An optician told us the acting manager had been extremely helpful, since they had taken up the management of the home in October 2014. A specialist nurse told us the home seemed to be "a lot calmer" in the last couple of months, and said the atmosphere had improved. Other comments from professionals included, "The acting manager is absolutely fabulous, very welcoming"; "I find the acting manager to be very pro-active, very switched on. There's been an improvement since she took over"; and, "We can see a lot of improvements. There is now a structured management which is receptive, professional and good to work with. The acting manager is very supportive of her staff."

Some of the staff were nervous and appeared worried when we first spoke with them. We found that this was due to historical issues at the service and our findings at the last inspection. They told us that things were much improved for them and the people receiving a service. They all spoke highly of the acting manager. Their comments included, "The acting manager is always supportive and accessible and the deputy goes out of their way to help me", and, "I am aware of the last inspection report but things are happening now and it's much better".

Care workers reported some ongoing lack of support on the individual units and described how they would benefit from easier access to the nurses and support and supervision with what they were doing. We fed this back to the acting manager who agreed that the ongoing lack of supervisions meant that staff of all designations, were, as yet, unable to share any concerns and ideas for improvement within a confidential environment.

Records showed that all designations of staff had met together with the acting manager on 5 November 2014. We saw this had been an open and frank meeting where staff had been able to voice their opinions and concerns. For

Is the service well-led?

example one person commented, “We were not being listened to in the past”. Another meeting was due to be held and it was apparent that the ongoing agenda was a team approach to improving the quality of care and safety.

A more recent meeting for the nurses who worked at the service had covered relevant topics such as team working, the importance of communications and nurse led aspects of care such as medicines.

Overall we found an improving emphasis on gathering everyone’s opinions and relevant information as to where the service had improved and what was still required to drive improvements forward.

The acting manager was an experienced nurse who had previously managed care homes and currently worked as a regional manager for the provider. She was now working full time at Pavilion Court and it was apparent that she had a clear picture of what was required to bring about improvements. She had control over the major refurbishment programme which was underway and talked us through the stages of this and the associated risk assessments which were in place. She felt the agreed embargo on new admissions should continue as this was allowing her and her staff time to implement changes which could be sustained and built upon.

Input from the provider was largely via the acting manager and records showed they had last visited the service in early December 2014. The provider’s representative, known as the Nominated Individual, was supporting the acting manager who told us, “I am being supported and my manager is there for me when needed and is keeping in regular telephone contact”. We saw established corporate systems for monthly electronic reporting and sharing of information such as complaints, discharges, and incidents of infection or accident with the provider.

The acting manager knew from her own audits that staff supervisions and annual appraisals were not up to date. She told us she had not yet had the opportunity to address this ongoing shortfall and had wanted to ensure that senior staff were skilled in coaching and supporting staff. However, this meant that individual staff members were still awaiting their opportunity to provide feedback and their personal views to the provider on standards at the service.

Through discussion with the acting manager, the management team and reference to records we found quality assurance systems were in place and were being followed. These involved lead roles for senior care workers, the handyman, housekeeper and nurses. Improvements in the audit and management of infection control issues were underway which included input and training from the NHS support team. The acting manager was not familiar with the recent NICE guidance relating to medicines in care homes but downloaded and distributed this to the staff team during the inspection.

Evidence of safety and maintenance such as fire checks, gas safety and checks on equipment was all in place and records and recording systems were in good order and very organised. Portable appliance testing of small electrical equipment was up to date as were Legionella control measures and water temperature checks. Accidents were reviewed regularly to assess whether lessons could be learnt to improve safety in the home.

We had previously raised concern with the provider over an apparent failure to notify us of serious incidents which had occurred at the service. At this inspection we established that the acting manager was prompt and thorough in notifying us of deaths, events and other incidents as required in respect of the Care Quality Commission (Registration) Regulations 2009.

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Suitable arrangements were not in place for the maintenance of appropriate standards of cleanliness and hygiene in relation to the premises.** Regulation 12 (2) (c).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Suitable arrangements were not in place to ensure staff were appropriately supported in relation to their responsibilities by means of appropriate supervision and appraisal. Regulation 23 (1) (a).