Caliburn (Care Homes) Ltd

Green Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 22 September 2015 and was unannounced. Green Park Nursing Home is registered to care for up to 30 older people with nursing needs. There is a passenger lift to assist people to the upper floors and the home is located close to a pleasant park area and transport links. On the day we visited the service there were 13 people living at the home.

The home did not have a registered manager in place.The home had been without a registered manager since 7 May 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 and associated Regulations about how the service is run. However, the home did have a manager who had been in post since June 2015 and who was completing the application form for registration with CQC.

At the last inspection on 14 January 2015 we found that there were breaches of four regulations. The provider sent us an action plan, outlining how they would meet the relevant requirements and in what timescale. When we visited the service, the timescales for completion had all been reached.

Summary of findings

At our last inspection 14 January 2015, we found that the registered person had not protected people against the risks associated with insufficient staffing. This was in breach of regulation18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection there were sufficient staff to care for people safely. This was no longer a breach of the regulation.

At our last inspection 14 January 2015, we found that the registered person had not protected people against the risks associated with inadequately supervised staff. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection people were cared for by staff who were supervised and supported in their role. This was no longer a breach of the regulation.

At our last inspection 14 January 2015, we found that the registered person had not protected people against the risk of insufficient involvement in decisions about their care or assessment of their mental capacity. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At this inspection improvements had been made. People were involved in their care which was provided with regard to their mental capacity. We saw evidence that decisions were made in people's best interests including a multidisciplinary approach in line with the requirements of the Mental Capacity Act 2005. However some people who required mental capacity assessments did not have these in sufficient detail to guide staff clearly. While this was no longer a breach of the regulation we have made a recommendation about this.

At our last inspection 14 January 2015, we found that the registered person had not protected people against the risks associated with receiving sufficient fluids and receiving appropriate pressure care. Also the environment was not sufficiently adapted to caring for people living with a dementia related illness. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection people were protected against the risks associated with receiving sufficient fluids and receiving appropriate pressure care. They received the clinical care they required in these areas and records of monitoring had improved. Staff and people they supported reported they were afforded the time to offer this care effectively. This was no longer a breach of the regulation.

Some improvements had taken place in providing items of interest and stimulation for people, including those who were living with dementia. This was no longer a breach of the regulation. However, although the manager had carried out research into this area, they had not yet addressed the need for signage to support people living with dementia. We have made a recommendation about this.

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?
The service was safe.

People told us that they felt safe. People had the opportunity to live a full life because of the way risk was managed.

People were protected by the way the service managed the control and prevention of infection. However, areas for further improvement were identified.

People were sure they received the right medicines at the right time however one medicine in use was out of date which meant people may be at risk.

There were sufficient staff who were safely recruited and a number were trained in how to safeguard people.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff were supported to meet people's needs. However they had not all received training in mandatory areas to enable them to more effectively carry out the duties they had been employed to perform.

People had access to healthcare services when they needed them.

People's mental capacity was assessed though this was not always in detail. This meant the manager could not be sure that people were supported appropriately around their capacity to make decisions about their care.

People were consulted about their meals, their nutritional needs were met and they had free access to food and drink.

Requires improvement

Is the service caring?
The service was caring.

Staff were skilled in clear communication and the development of respectful and caring relationships with people, involving them in all decisions. We observed that staff had respect for people's privacy and dignity.

People were cared for with compassion during their final days.

Good

Is the service responsive?
The service was not consistently responsive to people's needs.

People received good quality which had been discussed and planned with them.

Requires improvement

Summary of findings

People's interests and life histories had been recorded so that staff could understand people's needs. However, care was not always personalised around the provision of meaningful engagement.

People's views were listened to and acted upon by staff.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

The culture of the service was supportive of people who lived at the home and of staff. However this needed time to become embedded.

Staff understood their roles and responsibilities and lines of communication between them and the manager were effective. Staff were supported to improve their practice across a range of areas.

There was a quality assurance system in place and the registered manager was proactive in seeking out ways to improve. However, the results of quality monitoring were not always recorded to enable the manager to demonstrate improvements with written evidence.

Green Park Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 22 September 2015 and was carried out by one adult social care inspector and a specialist nurse advisor. The inspection was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered more information we needed during the inspection visit. We also reviewed the information we held about the service, such as notifications we had received from the registered manager. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

On the day of the inspection we spoke with six people who lived at the home, the manager and five members of staff. After the inspection we spoke with two health care professionals and one social care professional.

We spent time observing the interaction between people who lived at the home and staff.

We looked at some areas of the home, including some bedrooms (with people's permission), bathrooms, communal areas and office accommodation. We also spent time looking at records, which included the care records for seven people. We looked at the recruitment, supervision and appraisal records of three members of staff, a full staff training matrix and other records relating to the management of the home.

Requires improvement

Is the service safe?

Our findings

At our last inspection 14 January 2015, we found that the registered person had not protected people against the risks associated with not having sufficient staffing to meet people's needs. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the ratio of staff to people living at the home had improved. There were thirteen people living at the home at the time of inspection. The home had entered into a voluntary agreement with the local authority to limit the number of admissions while improvements were made to the safety and quality of care. This had led to a decline in the number of people living at the home over time. Staffing ratios had increased so that during the day there were the following; the manager, a nurse and three care workers with additional ancillary staff such as a cook, laundry assistant and cleaner. At night there was always a nurse on duty with a care worker. Staff told us this was a level of staffing which allowed them to care for people safely and to spend time chatting with people and engaging with them. Staff told us that inexperienced staff were on rota with skilled and experienced staff who could support them. We observed that staff were carrying out their duties without rushing and that they were spending time with people. The atmosphere was friendly and relaxed. People told us that there were enough staff to care for them and that if they ever had need to call them, they responded quickly. Staff told us that they felt the rotas were better organised. They said that the manager had arranged for staff to only have every other weekend on duty and that they were working reasonable hours, this meant that people benefited from care given by staff who told us they had sufficient rest times between shifts.

People told us that they felt safe and that there were sufficient staff on duty to assist them. One person told us, "The staff always help if you need anything, they come quickly when I call them." Another person told us, "I get my medicines when I need it. They are very good about that." Another person said, "They don't tell me I can't do something. I think they are well aware of the risks but they help me do what I can." Everyone we spoke with told us that if they ever felt unsure about their safety, staff would reassure them and deal with their concerns. This was no longer a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding training for most staff was up to date with a clear timescale in place for when updates were required. When we spoke with staff about this they were able to describe different types of abuse and the correct action they would take to protect people if they observed an incident of abuse or became aware of an allegation. Staff told us they felt the team would recognise unsafe practice and report it to the registered manager. Some staff had not yet completed this training. However, all of those we spoke with told us they would report anything which concerned them to the manager or other senior staff and that they would expect safeguarding to be dealt with by the local authority or the police, depending on the nature of the concerns. This gave us evidence that staff had the knowledge to protect people appropriately.

Staff told us that their approach to risk was responsive to people's changing needs and mental capacity. They told us that the home had an open and positive approach towards managing risk. For example, one member of staff told us, "We aim to support people to achieve what they want to do. We go out shopping with people who need us for confidence, and we are always available when people wish to move around the building." Another member of staff told us, "We are looking into getting a specialist wheelchair for a person so that they can get out and about. The risk of going out is small and we have discussed and agreed this with (the person)."

Staff told us that people's behaviour which others might find challenging was managed with a positive attitude. One member of staff told us, "We consult with the Community Mental Health team to give us strategies for managing people's behaviour in a positive way." Some staff had received training in how to deal with behaviour which may challenge, however others had not and were therefore not in a position to benefit from best practice advice in this area. We observed however, that staff were skilled in calming situations when people became upset or angry.

Behaviour risk assessments included advice from specialists and the service had purchased equipment such as door and pressure sensors. This was to alert them as people who posed a risk to themselves or others moved around the home.

Requires improvement

Is the service safe?

The manager told us that they had reviewed the way they agreed to admissions which placed more emphasis on balancing the needs of those people already accommodated at the home with the needs of any new admission, to ensure staff had the time and expertise to manage their care. This had led to a reduction in the number of admissions for people who had very complex or challenging care needs. Staff told us and our observations confirmed that this had resulted in a marked increase in people's general wellbeing and contentment within the home.

Care plans identified a person's level of risk and plans were detailed and specific to each individual. These were personalised and included consultation with people or their representatives. They considered people's level of independence and what support was needed to ensure independence was promoted. Risk assessments covered how to maximise people's freedom.

We checked recruitment practices within the home. Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to commencing work at the home and that employment references had also been received on all staff files we looked at. A DBS check helps to ensure that people who are known to be unsuitable to work with vulnerable people are not employed.

The home had a policy and procedure on staff discipline and the manager explained how they had used this in the last year to ensure people received safe and appropriate care. The home had a policy and procedure on whistle blowing, which was to support staff to raise a concern. Staff told us that they had confidence to raise concerns through whistle blowing and that they felt confidentiality would be protected.

We looked at the way in which medicines were managed. The home had a policy on the safe handling of medicines. Staff told us they were aware of this and some had received training. Only nurses administered medicines. The home used a Monitored Dosage System (MDS) with medicines supplied by on a 28 day cycle. (A MDS is where medicines are pre-packaged for each person).

Medicines were stored in a locked medicine trolley within a locked clinic room. This conformed to the manufacturers recommendations for storage. However, one item (eye drops) were approximately two weeks out of date which may have affected its efficacy. The manager told us they would remedy this. Controlled drugs were stored in a separate locked cabinet. They were checked, signed and recorded in a handbook on a daily basis. We observed that prescribed medicines were correctly dispensed by a registered nurse. Photographs were included in the medication chart to aid recognition. Medicine administration records were correctly completed, including the right codes (for example when people refused their medicine). Medicine disposal and clinical waste complied with legal requirements except where people's names had not been removed from the medicine bottles before disposal. This meant that in some cases people's confidentially was not fully protected. A fridge was provided to store certain medicines and the fridge temperature was monitored on a daily basis and recorded in a handbook. However, we observed two days where this was omitted. This meant that the manager could not always be sure that medicines stored in the fridge were at a safe temperature for people.

The manager told us that medicines were regularly reviewed. This was to ensure medicines were suitable and safe for current needs. Records of care planning reviews confirmed this. Staff were knowledgeable about individual's needs around medicines and any associated risks. For example they told us about pain relief medicines and how these were managed to make sure people received effective pain relief whenever needed.

The manager told us that they carried out a regular review of environmental risks and carried out regular safety audits. These were informal and as yet unrecorded, however we saw that a number of maintenance task had been completed. We saw records of accidents and incidents with actions and outcomes to protect people.

We observed that the environment was clean and that there were no obstructions to people wishing to move about the building. Although the building was not purpose built and did not support people to move around independently, we observed that staff took time to accompany people safely wherever they wished to go.

The service had received a visit from a Community Infection Prevention and Control Nurse Specialist (IPC specialist) on 18 March 2015. This highlighted a number of risks to infection control. At our last inspection the cleaning

Requires improvement

Is the service safe?

hours varied depending on the availability of staff. At this inspection we noted that the service had increased the cleaning hours to twelve a day. The cleaner did not share their time between this home and the sister home nearby which had been the case at the last inspection. We noted that chairs and soft furnishings had been cleaned or replaced, that the home smelled generally fresh and that some floor coverings had been replaced for ease of cleaning and to control cross infection.

However, there remained areas in the home where paintwork was chipped and where there was damage to hard surfaces which meant there was a risk of cross infection.

We saw records of training in infection control which some staff had attended, though some had yet to receive this training. Clear timescales were recorded for when this needed to be updated. We asked three members of staff about infection control and they understood what good infection control practice was to ensure people were protected. They referred to the use of aprons, gloves and the importance of hand washing when giving personal care to people.

Although improvements had been made to the safety of the service overall we did not improve the rating beyond Requires Improvement. This is because to do so requires consistent good practice over time. We will check this during our next planned inspection.

Requires improvement

Is the service effective?

Our findings

At our last inspection 14 January 2015, We found that the registered person had not protected people against the risks associated with inadequately supervised staff. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection staff told us that they received regular supervision, both on a one to one basis and, on most days, within a brief group meeting. Staff told us supervision covered discussion about quality care, their training needs and professional development. Supervision records we saw confirmed this. This was no longer a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection 14 January 2015, We found that the registered person had not protected people against the risk of insufficient involvement in decisions about their care or assessment of their mental capacity. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. The registered manager told us that a small number of applications had been made to the local authority for deprivation of liberty safeguards to be put in place and that there were two DoLS in place to protect people.

The registered manager told us that some staff had received MCA and DoLS training and records confirmed this. Some staff had not received this training. However, when we spoke with staff they were clear on the process for DoLS and mental capacity assessments as well as best interests decision making and the implications of lasting powers of attorney. These areas had either been covered in their National Vocation Qualification level 2 training or they had discussed this in meetings.

We saw that one person had required a recent Best Interests decision due to their impaired mental capacity, and this had been carried out by a multidisciplinary team in line with the MCA and the decision recorded.

The registered manager understood the implications of the Supreme Court ruling which had clarified the notion of deprivation of liberty for people in a care home setting. This meant that the manager had the information to protect people with regard to their mental capacity.

People told us they were regularly asked for their consent to care. We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response. When people declined, staff were respectful and returned to try again later if necessary.

People told us that they were consulted about their preferences around their care. One person told us, "They consulted with me about moving to this room, and it is better for me, it means I am now more independent." Another person told us, "They are good at guiding me to think again, when I get ideas that are really not practical, but they are also helping me to (do things) which we all agree I can do."

However, plans did not always include an assessment of people's mental capacity when this would be expected due to their observed level of cognitive impairment. This meant that people may not be involved as much as possible in decisions about their care because their level of capacity was not always clearly recorded. This was no longer a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we have made a recommendation about this at the end of the 'effective' section.

At our last inspection 14 January 2015 we found that the registered person had not protected people against the risks associated with hydration and pressure care. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection staff told us they had time to attend to people's care needs, and that this meant that people received sufficient drinks and their position was changed when they needed it as identified within care plans. People told us that staff had time to attend to their needs and we observed staff attending to people regularly. Jugs of juice and water were within easy reach of people who were able to help themselves to fluids. We also observed that staff

Requires improvement

Is the service effective?

regularly asked people if they would like something to drink. Staff filled in fluid and turning charts when in use, and though there were occasional gaps in recording, these were generally well completed and up to date. This gave evidence that people were protected against the risks associated with receiving fluids and pressure care. This was no longer a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were skilled in caring for them. One person told us, "The staff are kind and chatty, they really know what they are doing. I am confident with them. " Another person told us, "They are very good at coming round to check if I am okay. They got me this mattress which is really good, and I never feel I have been forgotten even though I am (often) in my room." Another person said, "They have all been told about my (medical condition) and they know how to help me with this."

We looked at staff induction and training records. Staff told us that they had received induction before they began their mandatory training. During this time they told us they developed a good understanding of each individual's care needs and the philosophy of the home. Staff were knowledgeable about the needs of people they supported and knew how their needs should be met.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people's individual needs and how risks were managed.

However, staff had not all received the full range of mandatory training. The member of staff who organised the training told us this had been due to a high staff turnover during the time when there had been no regular manager. Some staff had achieved the National Vocational Qualification at level 2 or 3 which meant they had covered most of the mandatory areas of training. However, some staff were relying on more experienced staff and guidance by the manager until their training could be arranged. This meant that staff did not all have the training to ensure they offered good quality care. We have made a recommendation about this at the end of the 'effective' section.

Staff told us that they had received one to one guidance from experienced staff in areas such as moving and handling people, infection control and safeguarding of adults. Staff had also received specially sourced training in areas of care that were specific to the needs of people at the home. For example, a number of staff had received training in dementia care.

The home had links with specialists, for example with the community mental health team, specialists in nutrition, sight and hearing and GPs. This helped them to offer appropriate and individualised care. Referrals for specialist input had been made when necessary, for example for the speech and language therapy team, (SALT), and specialist involvement from hospice professionals and tissue viability nurses who offered support in pressure care. Health care professionals us that the service had improved in the way they consulted with them about issues such as pain relief, end of life care and pressure care. They told us that the service sought advice appropriately and that they followed this. Staff confirmed that they actively sought external professional's advice. Advice from professionals had been incorporated into care plans.

Care plans included information about nutritional needs. People told us that they were asked for their preference in advance of meal times, and that if they changed their mind there was always sufficient extra to allow for this. On the inspection visit, the food appeared appetising. Staff asked people about their preferences and brought them drinks and snacks of their choice between meal times. One person told us, "I look forward to the meals, they are always good." Another person told us, "They go out into town with me so we buy the snacks that I prefer together." Another person said. "The meals are simple but good quality."

We recommend that the registered provider consults best practice guidance on training all staff to offer good quality care.

We recommend that the registered provider consults best practice guidance on assessing people's mental capacity.

Good

Is the service caring?

Our findings

People told us that all the staff and the registered manager showed them compassion and empathy and that staff gave them time and listened to them. For example they told us, "The staff are kind and thoughtful. One of them comes in and we talk about our interests." Another person told me, "They are always popping into my room with a cheerful comment and asking if I am alright." Another person said, "They have been really good at talking through things when I have been low and talking about what it'll be like when I improve, that really helps."

We spent some time with people in communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff and there was kindness between them as they chatted. We saw that staff encouraged people to express their views and listened with interest and patience to their responses. Staff gave the impression that they had time and spoke with people who were sitting so that they were on eye level with them.

When staff were assisting people with their meals they were focused upon the person, sat by their side and paced their assistance so that people were relaxed about the eating experience.

The way staff spoke with people demonstrated how well they understood individual needs and abilities. All were respectful in their interactions with residents and any visitors. Staff took time and care when they carried out care tasks and activities. Staff explained what they were doing and why and ensured that each person was comfortable when assisting them. We observed that staff visited people who spent most of their time in their bedrooms to ensure that they were comfortable, to offer drinks or snacks or carry out personal care activities.

Staff we spoke with told us that they enjoyed working at Green Park Nursing Home and had respect and affection for people they were supporting. One member of staff told us. "We have time to go into people's rooms and chat with them." One member of staff told us, "The care plans talk about people's need for care and respect and we really do offer that here." One member of staff told us, "We take an interest in people's lives, what they have done in the past, and care about what life is like for them now."

The staff and people we spoke with told us that the home encouraged visitors and we observed that a number of visitors were greeted by staff in a friendly way. Visitors told us that the staff always offered them refreshment and that they were made to feel welcome.

A health care professional told us, "I have noticed that the atmosphere in the home has improved over the last few months. When we come in here now it feels relaxed and happy."

The manager told us that they regarded the recruitment process to be very important in assessing potential staff for kindness and compassion. They told us that those who did not appear to have a good sense of empathy were not employed.

Staff told us about the way people were cared for in their final days. They emphasised the need for close liaison with palliative care professionals, attentive monitoring to ensure people did not suffer pain and how important it was to ensure people had company at their beside. We saw plans in place for pain relief and close monitoring. When people had Do Not Attempt Resuscitation plans in place these were correctly completed with consultation recorded.

Requires improvement

Is the service responsive?

Our findings

At our last inspection 14 January 2015, We found that the registered person had not protected people against the risks associated with an environment which was not sufficiently adapted to caring for people with a dementia related illness. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection aids to maintaining independence such as a clock with large face, signs indicating toilets, or identifying signs on people's doors to help them recognise their room were absent. Because signage was not available, staff could not be sure that independence was fully promoted. However, the manager had improved the environment with the addition of objects of interest, such as games, craft materials, soft toys and articles of clothing. They were in the process of consulting best practice recommendations regarding signage, and in the interim, increased staffing were assisting people to orientate around the home. We observed staff prompting people about the season and time of day. This was no longer a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave us a clear account of the care they had agreed to. Others told us they knew about their care plans but did not know what was written in them. Some people had signed care plans and we saw that written plans were regularly reviewed. This showed that people were consulted about their care.

Care plans identified people's goals which were identified in consultation with them. The care plan templates allowed for a detailed consideration of people's social, recreational and cultural needs. The manager had completed a life history and 'all about me' document which highlighted people's past experiences and their previous and current interests. However, in some cases these records were brief and did not give a holistic overview of the person and their needs.

People told us about their daily routines. One person told us about regularly going out with staff to the shops or café, another person told us that staff would sit with them and play cards. We observed staff engaging people in activities such as completing a colouring book, craftwork and reading. A small group was creating greetings card for one of the people who lived at the home. The manager had brought a puppy into the home and people were enjoying petting it. This prompted conversation about pets which people remembered of their own. Music and a muted television were being played in the lounge area. People were chatting with staff and the atmosphere was happy and friendly. All the people we spoke with told us they had enough to do and that the staff were good at engaging with them and making life interesting. However, the manager agreed that developing meaningful activities for people throughout the home had taken a secondary importance to ensuring that people's clinical care needs were met. Engagement with people did not sufficiently take into account people's specific areas of interest, or where relevant their physical, sensory or cognitive impairments. Insufficient attention had been paid to tailoring care to meet individual interests and choices. We have made a recommendation about this at the end of the 'responsive' section.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs.

Reviews focused on people's wellbeing and any improvements which could be made to people's care. Relevant specialists, the people concerned and any relevant family or carers were consulted for advice at these reviews. Monthly updates were recorded and these contained useful and relevant details to assist staff to plan responsive care.

Staff could tell us about people's care needs and how these had changed. They explained how referrals to health care professionals had been made to ensure care remained appropriate for each person. Records confirmed this. One health care professional told us that the home worked well with them, and consulted with them appropriately.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously, though they all told us they had never made any formal complaints. We saw that the service had a complaint procedure and staff told us this was followed. One person told us, "If I had anything to complain about then I would talk about any problem with the manager." Another person said, "I have been fine since I came here.

Requires improvement

Is the service responsive?

Anything I have not been happy with I have mentioned to staff and it has been dealt with." The service had a complaints procedure and the registered manager told us they followed this to ensure people's complaints were appropriately dealt with.

We recommend that the registered provider consults best practice guidance on tailoring support to meet people's social, cultural and recreational needs and preferences.

Requires improvement

Is the service well-led?

Our findings

At our last inspection 14 January 2015, We found that the registered person had not protected people against the risks associated with insufficient assessment and monitoring of the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the manager told us they carried out a range of audits on areas of quality and safety within the home, though a number of these were unrecorded. We saw checks on the lift, electrical wiring, emergency lighting and portable appliance testing. We also saw medicine audits. We heard from staff that the manager carried out regular infection control checks and that these were discussed with them. We saw that care plans had regularly been reviewed and that some had been updated with a new more comprehensive format. The manager told us that the results of monitoring checks were discussed in meetings and all staff were made aware so that any shortfalls were addressed to improve the overall quality of the service. Plans for improvements and progress towards achieving them were also openly shared with people who lived at the home on a one to one basis and people confirmed this. They told us they were kept informed, up to date and consulted. However, a comprehensive, recorded quality monitoring system was not yet operating. This was no longer a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, the service was not fully supported to focus on continual improvement. We have made a recommendation about this at the end of the 'well led' section.

There was no registered manager for the home. The home has been without a registered manager since May 2014. However, there was a manager, who had been appointed in July 2015. They were awaiting the return of the DBS check and were then planning to submit their application for registration.

People confirmed that efforts were made to hear and act on their views. There was a sense that the lines of communication between people and management were enabling and supportive and that there was an open culture. One person told us, "The manager comes round to talk everything through with us." Our observations of the manager during the inspection confirmed that they were a friendly and visible presence and that people, staff and visitors all appeared comfortable to approach them. While people's comments about the culture and ethos of the home were positive, the manager had only recently come into post and these improvements had not had time to be embedded.

Staff told us that the manager was approachable and supportive and that they were keen to listen to them and take their comments on board. The manager worked alongside staff so that any areas of concern could be quickly resolved. Staff told us that the manager actively sought their views in meetings and that suggestions were appreciated and encouraged.

The provider, manager and staff all spoke about looking for ways to improve the quality of life for the people who lived at the home. For example, staff spoke about developing the range of activities on offer to reflect people's interests. They told us they felt valued and that their opinions were respected.

The manager recognised where improvements needed to be made. For example, they had identified that people's life biographies and the recording of their interests could be improved and was working on this with a timescale in place. The manager had also identified that staff training was not up to date and had plans in place to remedy this. The manager was working to improve the way medicines were handled, to reduce the length of time each medicine round took whilst maintaining safety. We spoke with a community pharmacist who advised us that the manager had contacted them for advice about improving the way medicines were handled. This showed that the manager was proactive about making improvements.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support.

The manager told us how they updated their knowledge and practice with information from organisations recognised for advising on best practice. For example, the service was beginning to follow the Gold Standard Framework as a guide (about giving the right person the

Requires improvement

Is the service well-led?

right care, in the right place at the right time, every time). This had the potential to contribute to the personalised approach to care planning, however, work towards this goal was just beginning.

Communication with relatives and other interested parties was promoted through informal discussion. Surveys and questionnaires had not yet been devised. However, people who lived at the home and visitors told us that the manager regularly asked for their views on care, and that they were listened to and their comments acted upon.

Notifications had been sent to the Care Quality Commission by the service as required.

We recommend that the registered provider consults best practice guidance on developing an effective system of quality monitoring to support the service to focus on continual improvement.