Althea Healthcare Properties Limited

Highcliffe Nursing Home

Inspection report

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Website: www.kingsleyhealthcare.com

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 5 February 2016 and was unannounced. It continued on the 8 February 2016 and was announced.

Following our inspection of May 2015 the service was placed into special measures as the overall rating of the service was inadequate. People had not received safe or high quality care and the provider had not met a number of the fundamental standards. Improvement were needed in a variety of areas including staffing, management of medicines, management of risk, management of health and safety, staff training, management of people's legal rights, treating people as individuals, management of complaints, having a registered manager and notifying CQC of significant events.. During this inspection we found that significant changes had been made. However, further improvements were needed in staffing, management of risk, treating people as individuals, meeting CQC's requirements for a registered manager and reporting responsibilities to CQC.

The service is registered to provide accommodation and residential or nursing care for up to 46 people. During the inspection there were 33 people living at the service many whom were living with a dementia.

The service comprised of a ground and first floor providing accommodation. There were 46 bedrooms, 28 were single rooms of which 13 had en-suite facilities. Nine were double rooms of which four had en-suite facilities. The ground floor had two lounge areas one of which gave access into a secure garden area, a dining room and a conservatory. On the first floor there was a small dining room, which could accommodate four people, and a small lounge that could accommodate five people. There was a lift and staircases to the first floor. The service had specialist bathrooms, a kitchen, sluice and laundry facilities.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had submitted an application to become the registered manager.

We found that the service was not always safe. We found that staffing levels at some times of the day were not sufficient. This meant that people could not always have staff support them at times they needed. The service had not reviewed people's levels of dependency since July 2015 to determine the staff hours needed to support people with their assessed care needs.

The manager monitored accident and incident records monthly to check that risks to people were being managed. Staff had not consistently followed the reporting process. This meant that potential risks of harm to people had not been identified and any necessary actions taken to minimise them. People's risks were

assessed and reviewed regularly for malnutrition, skin integrity and moving and handling. Plans had been written that detailed the actions needed to minimise identified risks.

Medicines were stored and administered safely. Daily fridge and room temperatures were recorded to check the temperatures were within safe medicine storage limits.

Staff had completed safeguarding training and were able to tell us how they would recognise potential abuse and what actions they would take.

Staff had completed fire training and had been involved in fire drills. Fire equipment was regularly checked and maintained.

Staff were recruited safely and there were policies and procedures in place to manage unsafe practice.

People had the equipment they needed to support them.

We found the service was not always effective. The swallowing specialist had written a safe swallowing plan for a person. This provided detailed information for staff to follow to minimise the risk of the person choking. We observed the person being supported with their lunch and the safe swallowing plan was not followed which resulted in the person coughing. We observed staff supporting another person as their swallowing plan directed. We discussed this with the manager who told us that they would look at the reasons why staff had not been aware of the new swallowing plan and if necessary review the communication process.

People had their weight taken monthly. Any changes in a persons' weight were investigated and referrals to GP's and specialist professionals had been actioned. Food and fluid charts for people had been completed and monitored. People were offered a choice of meals.
On the ground floor people had a choice of where they wanted to take their meal. We observed people enjoying their lunch in the dining room, the lounge and in their rooms. Upstairs had more limited options for people as the lounge and dining room had limited space.

Staff had received induction training and on-going training that gave them the skills to carry out their role. They had individual supervision quarterly and also group supervision where practice was discussed.

We found that the service was working within the principles of the MCA. Care plans included details of a person's ability to consent and where they were unable to best interest decisions had been made. The manager was aware of which people had a power of attorney in place and the decisions they could be involved in on behalf of their relative.

People had good access to healthcare.

We found the service was caring. Staff had a good knowledge of the people they were supporting. Staff were described as approachable, kind and patient. We observed staff having good positive interactions with people, laughing together and sharing friendly banter. People were supported to keep in touch with their

families. Staff used picture cards and visual prompts to communicate with people who were not able to verbalise their needs or feelings.

People and their relatives felt involved in decisions and had access to an advocacy service. People had their dignity and privacy respected.

We found that the service was not always responsive. Assessments had been completed prior to people moving into the service and included information gathered from the person, their families and other professionals. People had care plans that were individual and clearly explained how people wanted to receive their care and support.
Staff demonstrated a good knowledge of the practical care needs of people and what they needed to do to support them. We found they did not always have an understanding of people's likes and preferences.

Care plans described how people liked to spend their time. We saw that people living downstairs had the opportunity to be involved in socialising with staff and visitors in the communal lounge area. Some people who were less able to communicate were awake and alert and watched what was happening around them. People living upstairs did not have the same opportunities to sit amongst other people in a social setting. This meant that some people were not being protected from the risk of social isolation and loneliness.

Some people needed staff to support them with daily exercises for stiff limbs. Exercise programmes were in people's rooms with diagrams demonstrating how staff needed to support people. Staff were carrying out the exercise plans and working with the occupational therapists.

An activities programme was in place that covered seven days of the week and required care staff to organise as part of their day. We were told that the service was in the process of recruiting a person to work full time as an activities co-ordinator. Some links with the community had been established.

Care plans were reviewed monthly or if changes were identified. Risks were understood by staff, discussed at handovers and actions agreed.

People and their families told us that they felt staff listened to them and took actions to put things right. A complaints process was in place and complaints were logged, investigated and the outcome fed back to the complainant including information on who to contact if they were unhappy with the outcome.

We found the service was not always well led. The service had not had a registered manager since 24 January 2011. A manager had been in post since May 2015. Their application for registration had not been submitted to CQC until November 2015.

Notifications were not always being sent to CQC. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

We observed senior staff communicating with each other and organising care staff to move to other parts of the service to provide support when it had been needed.

Staff meetings had been held monthly. Minutes included an action plan that was shared with the staff team. A staff survey had been completed in January 2016.

Relatives and staff told us the service was well managed. We observed a professional but relaxed relationship between the manager and staff team.

Audits had been completed by the manager which provided information on the quality of the service. They had highlighted any shortfalls, actions required and the person who needed to take the action, date action needed to be taken and notes on progress. A quality assurance survey had been sent to people and their families, other professionals and staff in June 2015. They had found the returns difficult to interpret and had made a decision to redesign the survey form so that it was easier to complete. The new form had been used in January 2016 to gather feedback from staff. We were told there was no confirmed date for the survey to be sent to people and their families and other professionals.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels at some times of the day were not sufficient. This meant that people could not always have staff support them at times they needed.

Staff had not consistently followed the accident and incident reporting process. This meant that potential risks of harm to people had not been identified and any necessary actions taken to minimise them. People's risks were assessed and reviewed regularly for malnutrition, skin integrity and moving and handling.

Medicines were stored and administered safely.

Staff had completed safeguarding training and understood how to keep people safe.

Staff were recruited safely and there were policies and procedures in place to manage unsafe practice.

Staff had completed fire training and had been involved in fire drills. Fire equipment was regularly checked and maintained.

People had the equipment they needed to support them.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always aware of people's swallowing plans which placed people at risk of choking.

People had their weight monitored and people at risk of not eating or drinking sufficient amounts had their food and fluid intake monitored. Referrals to GP's and specialist professionals had taken place when people's risks increased.

Staff had received induction training and on-going training that gave them the skills to carry out their role. They had individual supervision quarterly and also group supervision where practice was discussed.

We found that the service was working within the principles of the MCA. The manager was aware of which people had a power of attorney in place and the decisions they could make on behalf of their relative.

People had good access to health care.

Is the service caring?

Good

The service was caring.

Staff had good positive interactions with people, showed kindness, compassion and patience.

People were supported to keep in touch with their families.

People and their relatives felt involved in decisions and had access to an advocacy service.

People had their dignity and privacy respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff demonstrated a good knowledge of the practical care needs of people and what they needed to do to support them. They did not always have an understanding of people's likes and preferences.

Some people were not being protected from the risk of social isolation and loneliness.

An activities programme was in place that covered seven days of the week. Some links with the community had been established.

Care plans were reviewed and people's changing care and support risks were understood by staff.

A complaints process was in place and complaints were logged, investigated and the outcome fed back to the complainant including information on who to contact if they were unhappy

with the outcome.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have a registered manager.

Notifications were not always being sent to CQC.

Relatives and staff told us the service was well managed.

Audits were completed by the manager which provided information on the quality of the service.

A revised quality assurance survey had been introduced to gain people, their families, staff and other professional's views on the quality of the service.

Highcliffe 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.

The inspection took place on the 5 February 2016 and was unannounced. It continued on the 8 February 2016 and was announced. The inspection was carried out by two inspectors.

Before the inspection we looked at notifications we had received about the service and we spoke with social care and health commissioners to get information on their experience of the service. We did not request 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 this information from the provider during the inspection.

During our inspection we spoke with five people who used the service and 11 people who were visiting. We spoke with the Director of Service Quality, The Operations Manager, Manager and Deputy Manager, three nurses, eight care staff, one housekeeper and one member of the catering team. After our inspection we spoke with a health and a social care professional that had experience of the service.

We used 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 reviewed seven peoples care files and discussed with care workers their accuracy. We checked three staff files, health and safety records, maintenance records, medication records, management audits, staff meeting records and the results of quality assurance surveys.

We walked around the building observing the safety and suitability of the environment and observing staff practice.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2015 we found that the provider was not meeting the fundamental standards and people were not safe. Improvements were needed in a number of areas including, management of medicines, management of risk, staffing, equipment and the environment. During this inspection we found that significant changes had been made, however, further improvements were needed in relation to staffing.

We spoke with the management team who told us they felt there were enough staff to meet people's needs. Since the last inspection changes to how staff were deployed had been introduced. Staff told us these changes had helped. Two care workers each morning now started an hour earlier to support people to get ready for the day. One nurse told us "Staff suggested that one care worker could move between floors depending on where they were needed and this had helped". Although improvements had been made we found that there remained times when there were not enough staff. This meant that people could not always have staff support them at times they needed.

One relative told us "They are short staffed; as an example my relative is still in bed at lunchtime. It's not the care staff's fault". We read comments left by another relative that said "(Relative) in bed and in their pyjamas at noon. The occupational therapist wants them up a couple of hours a day". . Another person said "Staff say I can do that, I'll be back in a second and the second goes on and on". Another person told us "The girls chat for five minutes when they can but they don't often have time". We observed staff supporting people with their personal care and dressing until lunchtime on both days. One person was supported to get up at 12.58pm. The care worker told us "They have just got up. They would have had breakfast and continence care but this is first chance to get them up".

A care worker said "There isn't enough staff at various times of the day; mornings and evenings. The manager has had a big push for people to be out of bed but staffing levels mean people are in bed until late in the morning". Another care worker said "Sometimes staff time means people are late up, other days it's because people are sleepy". We discussed staffing with a member of the night staff. They said "There has been an improvement. We looked at the staff team and reallocated the rota so that there was a better skill mix".

After our inspection we spoke with a health professional who had visited the service over a weekend and had waited for over half an hour for senior staff to be free to speak with them due to their workload.

Staffing for both floors included a registered nurse, a senior and three care workers. We asked how staffing levels were determined. A management tool had been completed in July 2015 which calculated the level of dependency people experienced and the staff hours needed to support them safely. The management team told us that this needed to be revisited to ensure it reflected the current situation.

Staff were recruited safely. We looked at three staff files. Files contained evidence that references had been obtained, criminal records had been checked and that people were eligible to work in the UK.

Policies and procedures were in place to support the management of poor practice. A nurse said "If I see poor practice I tackle it straight away and have a confidential discussion. I will tell the person the standard I expect".

One person had bruising and a small skin break on their wrist which had been recorded in their care file. Records showed us they had bruising on the same arm some months prior to the current bruise. An incident form had been completed for the bruising identified previously but not for the bruising we had seen. The manager monitored accident and incident records monthly to check that risks to people were being managed. When risks had been identified actions had been taken to minimise them. Actions had included reviewing care plans, medicine reviews and referring people to specialist health professionals. Staff had not consistently followed the reporting process and therefore the incidents had not been connected or causes of the bruising investigated. This meant that potential risks of harm to people had not been identified and any necessary actions taken to minimise further bruising.

People's risks were assessed prior to admission and then reviewed regularly. They included malnutrition, skin integrity and moving and handling. Plans detailed the actions needed to minimise identified risks. Moving and handling plans contained detailed step by step information for care workers. Staff understood the risks to people and the actions they needed to take to reduce them. One relative told us "My (relative) was over sedated in the last place they lived. Here they treat them like a person, they've not been drugged. We know there are risks with falls but we can't fault them. It's about their quality of life". We looked at records of a review that had been held with a person and their family. The person had decided not to continue with a food supplement. The review showed that the person had understood the risk involved and their freedom to choose had been respected.

Medicines were stored and administered safely. Daily fridge and room temperatures were recorded to check the temperatures were within safe medicine storage limits. Medicine Administration Records (MAR) were signed and reflected the amount of medicines remaining. New medicines on the MAR sheet had been signed in by two members of staff in line with the services policy. Medicine that was prescribed to be given as required had additional recordings which included why the medicine was given and whether it was effective.

Some people were not able to verbalise when they were experiencing pain and nurses recorded their decision to administer pain relief on a pain assessment tool. Eye drops had been dated when opened and were in date. Some people were prescribed controlled drugs which have additional storage and administration requirements. We checked these and they were correct. Nurses were aware of people who needed their medicines outside the normal times medicines were given. One person had started having their morning medicine administered by the night nurse rather than after breakfast. Staff said "They're like a different person, it's been very beneficial". Creams were kept in people's rooms with a separate MAR sheet and a body map describing where any creams needed to be applied. We checked the MAR sheets for three people. The MAR sheets had been completed each morning but we found that creams prescribed to be administered more than once a day had not always been recorded as given.

Staff had completed safeguarding training and were able to tell us how they would recognise potential abuse and what actions they would take. Posters were displayed in the foyer for people and their visitors with information about safeguarding and who to speak to if they had concerns. People told us they felt safe. One person said "The girls are all nice and kind. I feel safer here than at home".

Staff had received fire training. Staff fire drills had been held in September, October and November 2015 and had included day and night staff. Procedures for fire maintenance checks had been clearly written and been followed. Equipment had been checked weekly and identified maintenance work completed.

People had the equipment they needed to support them with moving and handling and skin care. An occupational therapist told us "I visited a person and assessed them as needing a stand hoist and special sling. This was organised very quickly. The home have bought some equipment and also supported people to access equipment themselves". We spoke with a senior care worker who said "We have enough equipment. There are two hoists and we share the standing hoist. It's usually available".

Requires Improvement

Is the service effective?

Our findings

At our last inspection in May 2015 we found that the provider was not meeting the fundamental standards and people did not receive effective care. Improvements were required in relation to staff training and support, supporting people to eat and drink and ensuring people's rights were protected. During this inspection we found that significant changes had been made. However, improvements were needed in the way people were supported to eat and drink.

We looked at records for a person who had been assessed by a swallowing specialist as they had a risk of choking. A health specialist had written a safe swallowing plan. This provided detailed information for staff to follow to minimise the risk of the person choking. The persons care plan had been updated to reflect the swallowing assessment. We observed the person being supported with their lunch and the safe swallowing plan was not followed which resulted in the person coughing. The care worker and senior care worker were not aware the person's care plan had changed. We observed staff supporting another person as their swallowing plan directed. We discussed this with the manager who told us that they would look at the reasons why staff had not been aware of the new swallowing plan and if necessary review the communication process.

People had their weight taken monthly. If a person was at risk of malnutrition their weight was monitored weekly. A person had lost weight and a referral had been made to the dietician for an assessment. A relative told us "They do a fabulous job. When they came into the home they weighed 36kg and now they're 43kg". Some people needed to have their food and fluid intake monitored as they were at risk of poor drinking and eating and had charts in their rooms. The charts had been completed throughout the day by staff recording what a person had been offered and how much had been taken. The charts contained details of the target amount of fluid the person needed. We observed a shift handover between staff teams. Information shared included an update on two people who were at risk of dehydration. Staff demonstrated a good knowledge of the two people and how they needed to support them with their eating and drinking.

People were offered a choice of meals. The menu was displayed on a board in the dining room and on dining tables. Staff had plated meals and showed them to some people to help them understand the choices and choose what they would like. We observed staff supporting people with their meals. Staff supported one person at a time and at the persons pace. A relative told us "They go out of their way to give her the food she wants. Little and often".

On the ground floor people had a choice of where they wanted to take their meal. We observed people enjoying their lunch in the dining room, the lounge and in their rooms. Upstairs had more limited options for people which meant people could not always choose where to have their meals. The dining area was small and had one table and four chairs available for people to use. The size of the room prohibited people using it who needed specialist chairs. It was not used during our inspection. The lounge area was small and accommodated five people in their own recliner chairs. One person chose to take their meal downstairs and the other 10 people had their meal in their rooms.

Staff received an induction that enabled them to effectively carry out their roles. This included an introduction to the Care Certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. A care worker said "I was with a senior, they showed me how to do things and I read the care plans". We observed a new member of staff working with a senior care worker who was guiding their practice when they were supporting people.

Staff received mandatory training, role specific training and specialist training to enable them to effectively meet the needs of people. Training records were kept for each member of staff and included dates it needed to be reviewed. Training included dementia care, person centred care, infection control, health and safety and leadership and management training. One member of staff said "We have lots of training. The home are paying for English lessons". A nurse told us that they had received training to support the forthcoming Nursing and Midwifery Council's revalidation requirements. This demonstrated a commitment to clinical competencies and personal development. They said "We have had more comprehensive dementia training. We looked at managing residents with challenging behaviour and communication. It's sometimes about looking at the feelings behind the words".

Staff received individual supervision quarterly. A nurse said "I also carry out observational supervisions when the person has identified something that isn't a strength". Group supervisions had taken place to discuss observed practices with staff and had been used as a learning opportunity. Records were kept of all supervisions. We spoke with staff who felt supported in their role.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the service was working within the principles of the MCA. DoLS applications had been sent to the local authority for authorisation. Care plans included details of a person's ability to consent and where they were unable to best interest decisions had been made. Decisions included care and treatment, the use of bed rails, inability to use the call bell system and receiving medicines. The manager was aware of which people had a power of attorney in place and the decisions they could make on behalf of their relative. We observed staff asking for consent before providing any care or support.

People had good access to healthcare. This included GP's, mental health specialists, opticians, chiropodists and audiologists.

Good

Is the service caring?

Our findings

When we last inspected in May 2015 we found that the service was not treating people as individuals and had failed to treat people with respect. The service had also failed to respond professionally and compassionately to people's physical and emotional needs. During this inspection we found that significant improvements had been made.

Staff had a good knowledge of the people they were supporting. A visitor told us "Staff understand my friend. She is treated very well. Good clinical care, it couldn't be better. Staff are very patient". A relative told us "All the staff are approachable and helpful. Sometimes my husband isn't co-operative with care. The staff talk with him about the war and the job he used to do and this often helps". Another relative told us "My husband has been settled since day one. It's so homely. They telephone me if anything is happening. I feel able to talk to staff. All the staff make a point of talking to him". One person said "The girls are nice and kind.

We observed staff having good positive interactions with people, laughing together and sharing friendly banter. A care worker said "We never rush people but give them the care they need". We observed staff supporting a person to transfer from a wheelchair to chair. They gave clear verbal instruction to the person and explained what they were going to be doing. They ensured the person understood, kneeling down so that they were at eye level when talking with him. The person had been nervous and staff offered reassurance frequently whilst supporting them with the transfer. A care worker approached a person who would not have been able to independently move from where they were sitting to check they were comfortable. They said "Can you see OK, is the sun shining in your eyes". We saw one person sitting in the lounge who was quite withdrawn. Each time staff walked past they made eye contact and spoke to them which brought a smile to the persons' face.

The service had sourced from a dementia website a picture board that was used for people who were not able to verbalise their needs or feelings. One person would become quite anxious and they had found that talking books helped to relax them.

One persons' relative lived abroad and sent letters which staff read to them. Another person told us their family had been able to join them for Christmas dinner.

People and their relatives told us they felt involved in decisions. A relative said "Their care plan is shared with me and I feel any concerns are listened to". Another relative said "If I have any concerns I speak to the staff. I feel part of the family. I can talk to them all. I can always look in the care plan and they print a copy off for me. A further relative told us "Staff do tell me about things. If there's any problem they telephone which is what I have asked". People had access to an advocacy service and the details were displayed in the foyer.

People had their privacy and dignity respected. A relative told us "They are giving him his freedom here. He's more content. Dignity is a big thing and here they treat people with dignity". A care worker told us

"When I'm helping somebody in their room I close the curtains and door". We observed staff knocking on people's doors before entering their rooms. We saw that people had been supported with their clothing and personal appearance in a way that respected their dignity.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in May 2015 we found that the provider was not meeting the fundamental standards and the service was not always responsive to people's needs. Improvements were needed in a number of areas including, person centred care, ensuring people's care needs were reviewed and recorded and responding to feedback. During this inspection we found that changes had been made. However, improvements were needed to ensure people were at the centre of the care they received.

Assessments had been completed prior to people moving into the service and included information gathered from the person, their families and other professionals. People had care plans that were individual and clearly explained how people wanted to receive their care and support. The care plans described people's individual likes and dislikes, interests and hobbies. Families had been involved in providing photographs and life histories of people and we saw these in people's rooms and files. A summary of a person's care plan had been placed in each room. They were simple and provided clear instructions for staff on how to support a person... A comfort chart was in each room that staff completed and included a record of when a person had been repositioned and what they had eaten and drank. Two people were sharing a room and we found some of the comfort charts had been filed incorrectly in the other persons' file. This could have led to incorrect records being completed placing the person at risk of skin damage or dehydration.

Staff demonstrated a good knowledge of the practical care needs of people and what they needed to do to support them. We found they did not always have an understanding of people's likes and preferences. One person had specific instructions in their care plan of TV channels and programmes they liked to watch. The persons' family had very clearly stated the programmes that were not suitable for their relative. We found the person in bed watching a programme not in line with their care plan. They were not able to change channels independently or express their wishes. Another person had specific instructions not to leave their ceiling light on as it hurt the person's eyes. A sign had also been placed next to the light switch. We found the person in their room with the ceiling light on. Side lamps were available in the room but not being used and there were no available power sockets. The person was not able to independently manage the lighting in their room.

Care plans described how people liked to spend their time. One plan stated a person liked to go to the lounge mid- morning and that they seemed to enjoy musical activities. It read 'We always involve them'. A musical activity took place late morning but the person remained in bed and was not involved. A staff member said "The room is too small to fit everyone in
so staff will get them up this afternoon". On both days of our inspection the person was not supported into the lounge and remained in bed. We saw that people living downstairs had the opportunity to be involved in socialising with staff and visitors in the communal lounge area. The atmosphere was lively and people interacted with each other and staff. Some people who were less able to communicate were awake and alert and watched what was happening around them. People living upstairs did not have the same opportunities to sit amongst other people in a social setting. After our inspection we spoke with a health professional who said "When I visit upstairs nobody is sitting out but downstairs there are a lot of people

about". This meant that some people were not being protected from the risk of social isolation and loneliness.

One person liked to stay in bed in the morning and receive their personal care and get up in the afternoons. Another plan told us the person liked to have a sleep after breakfast, be offered a choice about going to the lounge but usually preferred quiet time. Staff had asked a person if they wanted to get up. We heard them telling staff "Leave me alone". The staff said "OK, do you want a drink; I will leave you". The person was able to eat and drink independently. Their care plan stated that they often declined to get up out of bed. These people had been supported by staff in line with their care plan.

An occupational therapist had carried out assessments for some people who had spent long periods of time in bed and their limbs had become stiff. Exercise programmes were in people's rooms with diagrams demonstrating how staff needed to support people. Staff told us that the exercises had really made a difference. After our inspection we spoke with an occupational therapist who told us "The staff are good at engaging and taking part in therapy plans. Recently the home telephoned to ask for a replacement sheet as the original had got wet so we sent it out in the post. We still get referrals for contracture management and the manager has been in touch for advice on how to support people out of bed". Staff had a sheet in rooms that they signed to confirm they had carried out the daily exercise plan. We found that they had not always been completed which meant we could not confirm that the exercises were consistently happening.

An activities programme was in place that covered seven days of the week and required care staff to organise as part of their day. We were told that the service was in the process of recruiting a person to work full time as an activities co-ordinator. Around the corridors we saw photographs of people enjoying social occasions, baking and birthday celebrations. A record was kept of activities that people had been involved in. They included a summer BBQ, cheese and port tasting and a carol concert. Some people had taken a trip to a local garden centre in December and staff, in their own time, had taken two people to a local pub. One person liked to watch Coronation Street. We spoke to a care worker who said "If we have time about 7pm we make a cup of tea and sit and watch Coronation Street together".

Some links with the community had been established. The local school choir had come in December and performed a Christmas concert. People, their families and neighbours of the service had been involved. Staff from a local beauty shop had come in December and did peoples hair and nails free of charge. A local vicar visited the service fortnightly. Their visit had included a harvest festival.

Care plans were reviewed monthly or if changes were identified. We observed a staff handover and information about people's health and mood were shared professionally. Information was given to the next shift about medicine that had been administered, events that had happened through the night, the actions taken and the reasons behind decisions. Risks were discussed and actions agreed that the next shift needed to take. Information was shared from the daily diary so that staff were aware of what was happening in the service that day.

People and their families told us that they felt staff listened to them and took actions to put things right. A complaints process was in place and information was displayed on the foyer noticeboard. Records showed us that complaints were logged, investigated and the outcome fed back to the complainant including information on who to contact if they are unhappy with the outcome.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in May 2015 we found that the provider was not meeting the fundamental standards and the service was not well led. Improvements were needed in a number of areas including, the management and leadership of the service, the governance and monitoring of the quality of the service and making the required notifications to the commission. During this inspection we found that changes had been made. However, improvements were needed in respect of meeting their legal requirement to inform CQC of any significant incidents

The service did not have a manager registered which is a condition of the provider's registration. The service had not had a registered manager since 24 January 2011. A manager had been in post since May 2015. Their application to become the registered manager was submitted to CQC November 2015 for assessment.

Notifications were not always being sent to CQC. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place. The police had been contacted as one person reported missing jewellery. CQC had not been notified of this incident which may have left people unprotected from abuse. We discussed this with the manager. They told us they had not thought the theft was reportable to CQC as it had not involved a police investigation. The manager agreed to familiarise themselves with information available from CQC that details reportable incidents.

We saw minutes of a nurses and senior carer meeting held on the 14 January 2016. The meeting had discussed concerns that nurses and senior staff had not been working well together. The main issue had been staff allocation. The meeting agreed that staff allocation and overseeing care staff would return to the responsibility of the senior carer with overall responsibility remaining with the nurse. We spoke with a nurse and a senior carer who had a good understanding of their role and responsibilities. During our inspection we observed senior staff communicating with each other and asking care staff to move to other parts of the service to provide support when it was needed.

Staff meetings had been held monthly. Minutes had been taken and included an action plan that was shared with the staff team. A survey had been completed by staff in January 2015 and a meeting had been arranged to discuss the findings with the staff team.

Relatives and staff told us the service was well led. One relative said "The Manager was open with us about previous issues". Another relative told us "The new manager is better than we have had previously. More caring, more upfront and approachable". A member of the staff said "I feel supported by the manager. The home is well managed".

We observed a professional but relaxed relationship between the manager and staff team. Staff told us that they didn't have a staff room to take their breaks in and this meant that they had nowhere to spend time away from their work which on some days was stressful. They had raised this with the manager and we were told that an area had been identified that would be converted into a staff room.

Audits had been completed by the manager which provided information on the quality of the service. Audits had included care plans, skin integrity, nutrition, medicine administration, falls and health and safety. Audits had highlighted shortfalls that had been identified, actions required and the person who needed to take the action, date action needed to be taken and notes on progress.

We spoke to the Director of Service Quality about the services quality assurance system. We were told that a survey had been sent to people and their families, other professionals and staff in June 2015. They had found the returns difficult to interpret and had made a decision to redesign the survey form so that it was easier to complete, condensed into three pages and covered the areas that CQC inspected against. The new form had been used in January 2016 to gather feedback from staff. We were told there was no confirmed date for the survey to be sent to people and their families and other professionals.