Newport Residential Care Limited

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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 took place on 29 and 30 October 2015 and was unannounced. The home provides accommodation for up to 31 people, including people living with dementia and mental health care needs. There were 30 people living at the home when we visited.

At the time of our inspection the manager had applied to be registered with CQC and their application was being processed. 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 home was split into two inter-connecting units. Support staff in the main part of the home supported

Summary of findings

younger adults with mental health care needs; care staff in the newer part of the home supported older adults, some of whom were living with dementia or had mental health care needs.

Risks to people living in the unit caring for younger adults were not always assessed and managed effectively as staff did not always have sufficient information about them. Individual risk assessments had not been completed for all people who smoked.

Arrangements to manage medicines safely were not robust. This meant it was not easy for staff to account for all medicines and medicine administration records were not always accurate. In some cases, there was a lack of information about when staff should administer 'as required' medicines.

Decisions taken on behalf of people in the unit caring for older people were not always documented in accordance with legislation designed to protect people's rights. However, staff were following the legislation that protected the liberty of people living at the home.

People living in the unit for younger adults were required to comply with a set of house rules, which included agreeing to daily room checks. These were not conducted on the basis of risk, so could compromise people's right to privacy. However, people were treated with dignity and respect at all times.

People were involved in assessing, planning and agreeing the care and support they received. Whilst some care plans were personalised and detailed people's individual needs, the care plans for people with mental health care needs sometimes lacked information about people's goals or objectives.

The manager conducted a range of audits on a monthly basis to assess, monitor and improve the quality of service provided. Where improvements were identified, prompt action was taken. However, the systems were not robust as they had not identified that some care plans and risk assessments lacked information; or that medicines were not always managed safely. Management arrangements were not resilient, although plans were in place to develop and appoint more senior staff.

People, staff and professionals felt the home was organised, well-led and praised the manager, who they described as "approachable" and "supportive". Staff understood their roles and worked well as a team. They were motivated, enjoyed working at the home and had good working relationships with external professionals.

Staff were responsive to changes in people's needs and supported them in a way that prevented unnecessary admissions to hospital. Reviews of care were conducted regularly and care records showed that people's needs were met. The provider sought, and acted on, feedback from people, for example in changing the activities they supported people to take part in.

People received effective care and support from staff who were suitably trained. Staff were encouraged to gain formal qualifications in health and social care and received appropriate support and supervision in their roles.

Staff used appropriate methods to help communicate with people who had difficulty expressing themselves verbally. They promoted a relaxed atmosphere and we observed positive interactions between people and staff.

Risks such as pressure injuries, malnutrition, falls and confusion, were recorded, monitored and managed effectively. People praised the quality of the meals and were supported to eat and drink well. The chef sought feedback from people and changed the menu to suit their needs and preferences. People were supported to attend health care appointments and saw doctors, psychiatrists, nurses and other health professionals when needed.

Staff were knowledgeable about the signs of abuse and how to report their concerns. There were sufficient staff to meet people's needs safely and checks were carried out on staff suitability before they started working in the home.

Appropriate arrangements were in place to deal with foreseeable emergencies, such as a fire. People had individual evacuation plans in place and took part in regular fire drills. Accidents were analysed and effective action taken to minimise the risk of recurrence.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Some risks to people were not always managed effectively and medicines were not always managed safely.

People felt safe at the home. There were enough staff to keep people safe and appropriate recruitment procedures were followed in all but one case.

There were suitable procedures in place to deal with emergencies and an effective system to analyse accidents.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not always follow legislation designed to protect people's rights, although they did protect people's liberty.

People received effective care. Staff were suitably trained and supported in their roles.

People's nutritional and hydration needs were met and they were supported to access health care services when needed.

Is the service caring?

Requires improvement

The service was not always caring.

Daily checks of people's rooms were not based on risk and could compromise their privacy.

People's dignity and respect were protected. Staff treated people with kindness and compassion.

Staff created a relaxed atmosphere which had a positive impact on people. People were involved in planning the care and support they received.

Is the service responsive?

Requires improvement

The service was not always responsive.

Goals and objectives were not always set for people with mental health care needs.

Staff delivered care and support in a personalised way according to people's identified needs and responded promptly when needs changed.

People were encouraged to remain as independent as possible.

The provider sought, and acted on, feedback from people.

Summary of findings

Is the service well-led?

The service was not always well-led.

Management arrangements were not resilient and quality assurance systems were not always robust.

There was an open and inclusive style of leadership. Staff understood their roles and worked well as a team.

Visitors were welcomed and there were good working relationships with external professionals.

Requires improvement

Newport Residential Care Limited

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 29 and 30 October 2015 and was unannounced. The inspection team consisted of an inspector and a specialist advisor in the care of people with mental health care needs.

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 also reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with eight people living at the home, two family members, a community mental health nurse, a visiting social worker and an external training provider. We also spoke with the manager, four care staff, five support staff, two members of kitchen staff and the administrator. We observed how care and support were delivered in communal areas. We looked at care support plans and associated records for eight people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records.

The home was last inspected on 17 September 2014, when we identified no concerns.

Requires improvement

Is the service safe?

Our findings

Staff in the unit caring for younger adults were not fully aware of all risks to people. Whilst most risks were assessed, monitored and managed effectively, some were not detailed or recorded well. For example, care records did not show whether risks presented by people in the past were still current. The records for two people showed they had attempted to self-harm in the past, but staff did not know the circumstances surrounding this. Where people posed an infection risk, there was no plan in place to protect staff or other people from this risk. A risk assessment for a further person showed they were 'vulnerable' but did not specify their vulnerability. This lack of information about people compromised their safety. The manager told us they had asked the referring agencies for this information, but had not been given it and they had not pursued it further. They did not use a referral form or require a minimum amount of information about people being referred to them. This meant they were not always able to manage and mitigate the risks to people effectively.

Some people living at the home chose to smoke. A smoking shelter had been provided in the grounds of the home, which people were required to use and, on admission, people had agreed not to smoke in their rooms as part of a personal contract. One person had been smoking in their room and we saw they had been given a warning about this. However, individual risk assessments had not been completed for all people who smoked, most of whom kept their cigarettes and lighters with them at all times. Therefore, the provider was unable to confirm that appropriate steps had been taken to assess and minimise the risks posed by people who smoked.

The arrangements in place to record and administer medicines were not always effective. We observed part of the evening medicines round and saw staff followed best practice guidance in the way they administered medicines. Medication administration records (MAR) were being used by staff. The MAR chart provide a record of which medicines are prescribed to a person and when they were given. We found that one medicine, which the MAR chart showed had been given in the morning, was still in its packet. The medicines for another person had been shown as not given in the MAR chart on one day, but an explanation for this had not been recorded. A further person had been prescribed a sedative to be given 'as required' (PRN). Staff had recorded the reasons for giving this on some days, but not on other days. The provider's policy required staff to record the reasons why medicines were not given and the reasons why PRN medicines were given, but staff were not always complying with this policy.

We also saw that five hand-written entries on one person's medicine records had not been checked by a second staff member, as recommended in guidance issued by the national Institute for Health and Clinical Excellence (NICE). Therefore the provider was unable to demonstrate that people were receiving all their medicines safely and as prescribed. We identified a potential discrepancy with the number of tablets in stock for one person. Staff took several hours to resolve the issue as tablets had been received into the home in several batches at different times. Additional tablets were found in stock for one person, which were not recorded on their MAR charts. Staff told us the person had been given the tablets after being discharged from the hospital, but they had not been recorded. These anomalies demonstrated that recording methods used by staff were not robust.

Three people were prescribed PRN medicines to reduce their levels of anxiety. For two people there was no information available to guide staff about when these should be administered. For another person, this information was limited; it advised staff to contact the mental health crisis team after an hour and a half, before giving a second dose, but did not specify the circumstances in which this would have been appropriate. This meant people may not have received PRN medicines in a consistent way.

The failure to manage and mitigate risks to the health and safety of people effectively and the failure to manage medicines safely were breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Other aspects of medicines management were safe. A clear process was in place for administering topical creams. This used body maps to assist staff in understanding where they should be applied, and records confirmed these had been applied as prescribed. Three people had requested, and been assessed as capable of managing their own medicines. Secure storage was available in their rooms and staff supported people appropriately with these when needed. Staff understood that people's mental health needs varied from time to time, so offered flexible support.

Requires improvement

Is the service safe?

For example, one person, whose mental health had deteriorated recently, asked staff to take over the management of their medicines, which we saw they had done. When a person was found to be intoxicated staff sought advice and delayed giving the person their medicines, as they may have caused an adverse reaction.

Individual risks, such as pressure injuries, malnutrition, falls and confusion, were recorded for each person and managed effectively. Staff were aware of each person's risk assessment and knew how to support them in the safest way possible. For example, where pressure relieving equipment was needed, we saw this was being used. Where people had developed pressure sores, good use was made of photographs to monitor whether sores were improving or degrading and this had led to good outcomes for people. Staff had identified that an aid used to support a person to stand was not appropriate for the person's weight. A more robust stand-aid had been ordered and, in the interim, staff were using a hoist to support the person to move.

Staff supported people to take positive risks to help them maintain links with the community. For example, one person's care plan stated that "The person has capacity to make his own decisions. He may decide to go out without telling staff. This has been discussed with [the person] and the risks have been acknowledged by staff and with [the person] signing to show this." A simple plan had been devised to support the person to manage the risk without compromising their independence.

People told us they felt safe at the home. One person said, "I'm very happy here; I feel safe and secure." Another person told us "I've lived elsewhere, and this is the safest I've felt anywhere." Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and knew how to contact external organisations for support if needed. They were encouraged to raise concerns with the manager and told us there would be "no question" that the manager would act immediately. Two kitchen staff had not received safeguarding training, which the manager told us would be addressed. The service had suitable policies and procedures in place to safeguard people and their property. For example, one person was at risk of financial abuse due to their personal circumstances; staff had provided advice and were supporting the person to help reduce the likelihood of them being taken advantage of by others. Staff responded appropriately to any allegation of abuse. The manager had conducted an investigation into a concern raised recently, which had been thorough and robust; it showed that the person concerned had not been harmed and that staff had acted appropriately at all times.

There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner. One person told us "There's always someone to support you if you want help, or to go shopping, or just for moral support at the doctors." Most staff were highly experienced, having worked at the home for a long time, and were skilled at supporting people. Staff were split between the two units but provided mutual support to one another when needed. People told us this arrangement worked well and staff were always available to support them.

Staff were subject to checks to see if they were suitable to work in care. Checks with the Disclosure and Barring Service (DBS) were carried out before staff were permitted to provide support to people living in the home. The DBS helps employers make safer decisions when recruiting staff to work in the provision of care. References as to the conduct of staff in previous employment were obtained, although we found a reference had not been sought from the most recent care provider that one member of staff had worked for. This meant the provider had to rely on less recent evidence of the staff member's performance, which may not have been up to date. People had been involved in the recruitment of new staff. The manager invited applicants to visit the home and meet people. They had then asked people for their views about the applicants and these were considered, along with the formal processes, when deciding who to appoint.

Each person had a personal emergency evacuation plan (PEEP) which showed the support they would need if they needed to leave the building in the event of an emergency, such as a fire. These were kept in accessible 'grab bags' together with emergency equipment and information about the home that staff may need in an emergency. Staff had been trained in fire safety, knew what action to take if the fire alarm was activated and took part in regular fire drills. Staff told us a recent fire drill was repeated as some people did not respond appropriately to the first one. This stressed the importance of good fire safety procedures to staff and people living at the home. Weekly checks were made of the fire alarm, the means of escape, emergency

Requires improvement

Is the service safe?

lighting and automatic door release devices to make sure they were operating correctly. If staff in one unit needed urgent support from staff in the other unit, they used a recognised signal to alert their colleagues.

All accidents and incidents at the home were recorded in detail, together with the action taken to prevent a recurrence. For example, a person was scalded when they spilt a cup of tea in their lap. Their risk assessment was reviewed and safety measures put in place. The including supporting the person to sit upright when they drank and giving the person slighter cooler drinks. A staff member told us "If [the person] wants their tea hot, we now sit with them while they drink it to make sure they don't spill it." Incident records were reviewed by the manager to analyse and identify any common causes. Following incidents of friction between two people, the manager had circulated a letter to people reminding them of the dangers of borrowing or lending property, money or cigarettes to others.

Requires improvement

Is the service effective?

Our findings

Staff sought verbal consent from people before providing care or support and were able to explain the principles of the Mental Capacity Act, 2005 (MCA). However, staff in the unit caring for older people did not always follow the MCA in practice. The care records for two people living in this unit contained information which identified that they were living with a cognitive impairment and lacked capacity to make certain decisions. However, there were no records to show how those assessments had been made. Best interests decisions had been recorded in their care plans to allow staff to use bedrails to restrict their movement and keep them safe. The decisions had been recorded by a doctor, but the doctor was not the designated decision maker in these cases and there were no records to show that people's families had been consulted.

Most people had signed their care plans to indicate their agreement with it. However, the care plan for a person living with dementia had not been signed and staff had not assessed the person's ability to consent to their care plan or made a decision to show that the care and support planned was in their best interests. Staff had invited the relatives of two other people to sign consent forms when they did not have legal authority to act on behalf of the people concerned.

The failure to follow the MCA and its code of practice was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. DoLS applications had been made for four people and the registered manager was waiting for the local authority to complete assessments. Staff understood the significance of these applications and the support people needed while they were being considered.

People received effective care from staff who had the necessary skills. One person told us "The home's been good to me. Staff are very good and know what they're doing." Another person said, "I like it here; I wouldn't want to go anywhere else." A family member described staff as "helpful and knowledgeable". A visiting social worker confirmed this and said, "Staff have the skills needed to support people. [One person] can be very confrontational, but staff are good at negotiating with [the person]."

Staff had completed a wide range of training relevant to their roles and responsibilities. Staff praised the range and quality of the training and told us they were supported to complete any additional training they requested. New staff recruited since April 2015, completed an induction and training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. The manager reinforced learning by staff during staff meetings by holding quizzes based on topics that had been taught or refreshed recently. Consequently, staff were able to demonstrate a good understanding of the training they had received and how to apply it.

Staff had completed, or were undertaking, vocational qualifications in health and social care. Three staff members were being supported to complete higher level diplomas to develop their supervisory skills and enable them to undertake some management responsibilities. One of the staff members said "I'd always been told I couldn't do it, then [the new manager] came in and supported me to go for it." An external training consultant told us "[The manager] is very supportive of staff training; we find [staff] are good at evidencing the skills needed for each unit [of training] they complete."

Staff received appropriate support in their roles through the use of regular supervisions and annual appraisal. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. Records of supervisions showed a formal system was used to ensure all relevant topics were discussed. Where actions were identified the process ensured these were reviewed at the subsequent supervision meeting.

People praised the quality of the food. One person said, "The food's alright and there's lots of it." Another person told us "The food is lovely and there's always a choice." A family member told us "It's lovely here; the food's good and he gets lots to eat." People were offered varied and

Requires improvement

Is the service effective?

nutritious meals appropriate to the seasons. Staff who prepared meals were aware of individual likes and dislikes, allergies and preferences. Meals were appropriately spaced and flexible to meet people's needs. In the unit caring for younger adults, people were able to make drinks in a small kitchen area; in the other part of the building staff made drinks for people and encouraged them to drink well. Staff provided appropriate support where needed, for example by encouraging people to eat and supporting them on a one-to-one basis where needed. Special diets, including pureed and fortified meals were available for people who required them.

Staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration and took prompt action when people started to lose weight. A staff member told us "If people go off their food, we involved the chef and chat to the resident about what they fancy. If we have no success, we refer them to the GP." We saw changes to people's meals had been made following these discussions. One person preferred to eat fish and chips out of take away containers, so staff had acquired some of these containers to put the person's food in. As a result, their nutritional intake had improved. Staff also described how they supported a person with limited vision by turning the plate around half way through the meal to allow them to see parts of it that were otherwise invisible to them.

Staff were alert to changes in people's health needs and had good working relationships with health and social care professionals. These included doctors, district nurses, social workers and mental health specialists. Records were kept of their visits as well as any instructions they gave regarding people's care and support. Some people in the unit caring for younger adults required regular medicines via injections for their mental health needs. Staff supported people to attend these injections at community clinics or at the home when needed. Some people in the newer unit had difficulty swallowing food and fluids; they had been seen by speech and language therapists and staff were following their advice.

Requires improvement

Is the service caring?

Our findings

Some people living in the unit caring for younger adults received support by being given structure to their lives and being encouraged to follow a set of 'house rules' for the safety of themselves and others. One of the house rules required them to agree, as a condition of residence, to daily room checks by staff. Whilst these provided an important form of support for some people, others told us they found the checks "intrusive". The manager and staff told us that the checks were conducted to safeguard people by, for example, checking that they had not over-loaded power sockets, were not bringing alcohol or drugs into the home, or storing out of date food items that could harm them. However, the checks were not conducted on a risk basis or according to people's individual support needs, and staff told us they rarely found any item of concern in some people's rooms. Therefore, the blanket application of this policy risked compromising people's right to privacy.

In other respects, people's privacy was protected. Staff knocked on people's doors, and waited for an answer before entering. Confidential information, such as care records, were kept securely and could only be accessed by those authorised to view it. Staff spoke respectfully and discreetly to people about their needs. People could choose whether they preferred a male or a female member of staff to help with their personal care and their preference was respected.

Staff treated people with kindness and compassion. One person said, "Staff are very good. They treat you with respect." Another person described staff as "lovely, happy people". A family member said of the staff, "They're very good to [my relative]. They welcome us and are very nice to us."

Staff helped build positive relationships with people, yet were aware of the need to maintain professional boundaries when supporting people. A staff member told us "[People living at the home] know they can come to me. I'm not a friend, I'm here to help. You have to know the boundaries to be able to support people properly." People were supported to maintain friendships and important relationships with people in, and outside of, the home. Their care records included details of birthdays and important anniversaries for them and family members close to them and staff supported them to celebrate these occasions.

Staff used appropriate methods to help communicate with people who had difficulty expressing themselves verbally. For one person, we saw staff used a series of flash cards to help the person express themselves. Staff coupled this with their knowledge of the person and the responses they expected to each flash card shown. For example, when the person did not make a clear response to any of the drinks shown on the cards, staff gave the person their favourite drink, which they then drank readily.

Staff promoted a relaxed atmosphere and people responded to this positively. When a person started to sing whilst walking through the hallway, several staff joined in with them. The person showed they enjoyed this by singing louder and louder. Staff also knew people and their backgrounds well. When a person appeared to be bored, a staff member approached them and suggested they looked at a book related to the person's previous job. This promoted a positive conversation with the person about their working life.

During the inspection, three people changed rooms in order to accommodate their needs more effectively. Two of these involved moves from one part of the home to the other. All moves went well and the people concerned told us they were "very happy" with their new rooms and the support staff had given them.

Prior to moving to the home, people were involved in assessing, planning and agreeing the care and support they received. Care plans were then developed to meet their individual need. One person told us "I have my own worker and discuss my care plan with them." Comments recorded in care plans showed people were continually involved in this process and family members (where appropriate) were kept up to date with any changes to their relative's needs. A staff member confirmed this, saying, "We do monthly updates of the care plans and give everyone the opportunity to chat about them."

Requires improvement

Is the service responsive?

Our findings

People received personalised care from staff who supported them to make choices and were responsive to their needs. One person said, "The staff are good; I've got better since being here." Another person told us "I get all the help I need. [The staff] will do anything for you." A community mental health nurse told us the home "met lots of the needs of the residents; promoted independence as much as possible and adapted to the needs of the person".

Staff in the unit caring for younger adults recognised that some people's mental health was highly variable and could change quickly. 'Relapse indicators' were recorded in people's care plans to help staff identify signs when a person's mental health might be deteriorating. These were developed over time as staff got to know people better. For example, staff were aware that some people found certain times of the year difficult, so monitored their welfare more closely at these times. Staff were alert to changes in people's behaviour or mood and shared concerns with colleagues during handover meetings at the start of every shift. This allowed appropriate support to be offered and prompt referrals made to mental health professionals when needed.

On the night between the two days of our inspection, a person started presenting as unwell with hallucinations and required taking to hospital for assessment. The manager, who was on call, attended the home and accompanied the person to the accident and emergency department. They reassured the person throughout the process, which helped the person become calm and relaxed. Medical staff felt the person anxiety levels had reduced, so they did not need to be admitted to the hospital and were able to return to the home. The following morning, additional support was provided by the community mental health team and the person was able to take part in a normal day's activities. By knowing the person well, and acknowledging and responding to their needs, staff helped the person avoid a potential admission to hospital, which may have resulted in a very different outcome for them and their mental health.

Whilst staff in the unit for people with mental health care needs knew people well and were responsive to their needs, they were not always supported by the care plans. We found some care plans were not clear and lacked key information about the support people needed. In some cases this was due to incomplete information supplied by referring agencies. In other cases, there were no clear objectives or goals set for people to show the purpose of the support being given. For example, the care plan to support the 'psychological needs' of one person identified that they were 'depressed', 'anxious' and prone to 'self-neglect', but there was no plan to inform staff how to support the person with these needs. Medical notes showed that a person had previously been referred for a CT scan to see if their illness had an organic cause. They had declined to attend the scan, but staff had not followed this up since the person's circumstances and mental health had stabilised. We discussed these cases with the manager, who agreed the care plans could be improved. However, other people's care plans were more detailed. They contained clear guidance about the type and level of support needed and staff acted as advocates to make sure people received appropriate support from other services. A staff member told us "We sometimes have to persevere [with health professionals] but we push and push until people get the help they need."

Care plans for people in the unit caring for older people were comprehensive and provided detailed guidance about the way care and support should be delivered to each person in order to meet their individual needs. People's daily routines in the morning and evening were recorded, including how and where they liked to spend their day; staff were familiar with their routines, but remained flexible and were led by people's choices. Some people in this unit were not able to tell staff when they needed pain relief, so clear guidance had been developed to help staff identify when people were in pain. This included looking at the body language people displayed and the individual signs they made. People's daily records of care were up to date and showed care was being provided in accordance with people's needs.

To appreciate the importance of delivering care according to people's individual needs, some staff had been asked to write a support plan for themselves, imagining that they were receiving the service. The manager told us "It made [staff] appreciate that it's not just about the care and support they need, but how they want to receive it." A staff member said, "It's made us always think about the residents first and how what we do affects them."

Reviews of care were conducted regularly by nominated key workers. A key worker is a member of staff who is

Requires improvement

Is the service responsive?

responsible for working with certain people, taking responsibility for planning that person's care and liaising with family members. As people's needs changed, their care plans were developed to help ensure they reflected people's current needs. A community mental health nurse confirmed this, and told us staff "refined care plans as needed in response to the changing needs of residents". People and their relatives were consulted as part of the review process and their views were recorded. A family member told us "I haven't seen the care plan, but I don't need to as [staff] talk to me about it and I know they look after [the person] well." Records of care and support delivered were maintained and showed people had been supported in accordance with their plans and their needs were met.

People in the unit caring for older people had access to items of interest and amusement to stimulate them mentally. These included rummage boxes and bags and tactile materials, such as simple musical instruments and textiles for people to touch. Staff used these to promote conversations and engaged with people spontaneously, playing games, dancing and singing, which people clearly enjoyed.

The provider sought, and acted on, feedback from people, relatives, staff and professionals to help identify ways of improving the service. Following comments made by people in response to a survey conducted by one of the chefs, changes to the menu had been made, such as fewer stews, and new foods had been introduced, such as continental breakfasts and chicken nuggets, which had proved popular. People had also been consulted about activities they wished to take part in and places they wished to visit. Some of these trips had taken place and others were being arranged. The provider also planning to conduct a comprehensive satisfaction survey by sending questionnaires to people and their families. The manager was able to explain how the results would be analysed and used to improve the quality of service provided. There was an appropriate complaints policy in place, which people and relatives were aware of. No complaints had been recorded for the past year.

Requires improvement

Is the service well-led?

Our findings

People were happy living at the home and felt it was well-led. One person said, "It's well organised. [The manager] and staff are lovely." Another person told us "Things run better now. I'm much happier." A family member said of the staff "They always make me very welcome."

The manager conducted audits of key aspects of the service on a monthly basis to assess, monitor and improve the quality of service. These included care planning, medicines, infection control and the environment. Where deficiencies were identified, prompt action was taken to rectify the issues and these were monitored to make sure they were completed. However, the quality assurance system had not identified that the arrangements for managing medicines were not always safe; that best interests decisions were not always made in accordance with legislation; or that risks to some people were not always managed effectively. This meant they were not always robust. We discussed this with the manager, who agreed to review their processes.

The manager was supported by the provider, who visited regularly and an administrator. However, management arrangements were not resilient as there were no other senior staff employed and the manager received limited support on day to day basis. For example, the manager was responsible for conducting appraisals and regular supervisions with all 28 staff members, which placed a heavy burden on their time. To address this, the manager had identified two experienced staff members with supervisory skills, who they were supporting to obtain higher level diplomas in health and social care. In due course, they would then be appointed to senior roles in each of the two units. This would provide greater resilience and allow the manager more time to focus on strategic issues.

Staff praised the manager, who they described as "approachable" and gave examples of how they had been supported in their roles. One member of staff told us "I love it here. The back-up from staff and management has been excellent." Another staff member said they felt "listened to" and the support they received had made them "more confident" when supporting people.

Staff were aware of the provider's vision and values and how they related to their work. The manager adopted an open and inclusive style of leadership. Staff confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously. One staff member told us "[The manager] is always quite open and willing to listen. There more input [from staff] and more discussion about issues now and she goes out of her way to thank us.

There was a duty of candour policy in place to help ensure staff were open and transparent in their dealings with people and their families. Visitors were welcomed, the provider notified CQC of all significant events and there were good working relationships with external professionals. A visiting social worker told us "Since [the manager] arrived, morale is higher, staff are more engaged and focused and more positive. There's good, proactive, leadership."

All staff understood their roles, were motivated, committed and worked well as a team. Most staff predominantly worked in the unit they were assigned to, but were able to support staff in the neighbouring unit when needed and maintained good communications between one another. One staff member said, "I actually like coming to work now as I feel everyone is well looked after." Another told us "The home runs well and the main thing is the residents are happy."

Regular staff meetings were held, including meetings with key staff in each unit. These were used as an opportunity to discuss people and their needs, together with any staff concerns. A staff member told us "The meetings are really good. We go over [the manager's] agenda, then our agenda and get a quiz to check our knowledge of things like fire procedures."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not following the Mental Capacity Act, 2005 and ensuring service users were only treated with consent. Regulation 11(1), 11(2) & 11(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not ensuring that all risks to people were managed effectively or that all medicines were managed safely. Regulation 12(1), 12(2)(a) & 12(2)(g).