Oldbury Grange Nursing Home Ltd

Oldbury Grange Nursing Home

Inspection report

Oldbury Road
Hartshill
Nuneaton
Warwickshire
CV10 0TJ

Tel: 02476398889

Date of inspection visit:
03 May 2016
04 May 2016

Date of publication:
14 June 2016

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 3 and 4 May 2016. The visit was unannounced on 3 May 2016 and we informed the provider we would return on 4 May 2016.

Oldbury Grange provides accommodation, personal and nursing care. Since our last inspection, an extension has been built and the home is now registered for up to 89 older people. The home has two floors; the ground floor provides nursing and residential care to older people living with complex health conditions. The first floor has two units; one nursing and one dementia care. The home provides end of life nursing care to people. At the time of the inspection 79 people lived at the home.

The home is required to have a registered manager in post. 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 and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager in post.

At our previous inspection in February 2015 we found two breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. People were not always protected against the risks of acquiring an infection because appropriate standards of cleanliness and hygiene were not maintained. People's safety and welfare was not always ensured because there was not sufficient staff available at all times to meet their needs. We rated the home as 'Requires Improvement' and asked the provider to send us a report to tell us what action they had taken to become compliant with the regulations.

At this inspection we found improvement had been made to the extent that the provider was no longer in breach of the regulations. However, some further improvement was still required. The registered manager informed us that they had recently recruited ten new staff members as a number of staff had recently left. Some of the improvements needed, identified during this inspection, stemmed from the number of new staff on shift who had not worked at the home long enough to know the people they cared for, and to receive all the training required to work effectively. Plans were in place to provide training to new staff in May and June 2016. Improvement had been made to the environment taking into consideration the needs of people living with dementia. Whilst most staff had completed dementia awareness training, further specialised dementia care training was planned for existing and new staff.

We found people had their prescribed medicines available to them, however, we saw insufficient checks were made by staff to ensure people had consumed their prescribed food supplements and creams applied as needed. Assessments were in place to identify risks to people but risks were not managed consistently by staff because they did not always have the information or training they needed.

Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The manager understood the Act and made referrals when needed but had not always fully considered their responsibilities under this law in using bed rails for people.

We saw nutritious meals were available to people. However, choices were not always offered and people were not always offered the support they needed to eat their meal. Staff told us they felt there were enough staff allocated to each shift, although new care staff were still getting to know people and their needs.

People's care records were not sufficiently detailed to support staff in delivering care in accordance with people's needs and wishes, and staff were not always able to tell us about people's needs. A range of social activities were offered to people and met the needs of some people.

Systems were in place to assess the quality of the service provided. Some audits were effective in identifying issues and action to improve was implemented. However, other audits were not always effective. Some people and relatives were asked for their feedback on their experiences of using the service and this was analysed, but other people and their relatives had not been included in the survey for their feedback. Informal concerns and complaints were not always recorded.

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 consistently safe.

Staff understood their responsibilities to protect people from abuse and would report concerns. Although risks associated with people's care were assessed actions were not always put into place to reduce the risk of harm. Staff did not always have the training, skills or information they needed to keep people safe. While sufficient numbers of staff were on shift, some carer workers were newly appointed and had not yet completed all their planned training. People had their prescribed medicines available to them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The provider understood the Act, but had not always fully considered their responsibilities under this law in using bed rails. People were not consistently offered choices or given the support they needed to eat and drink. People were supported to maintain their health and were referred to health professionals when needed.

Is the service caring?

Good

The service was caring.

People and their relatives told us that staff were kind and caring towards them or their family member. We observed positive interactions between people and staff. Staff maintained people's dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that was personalised to them. People's care plans were not always detailed to support staff in delivering care in accordance with people's needs and

preferences. Some social activities were offered for people to pursue their hobbies, interests or engage in social interaction. Concerns raised by relatives were not always resolved.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had systems in place to monitor the quality of the service provided but these were not always effective. Staff told us they felt supported by the registered manager. A positive, no-blame, culture was followed by the registered manager and staff team that looked for solutions to issues identified.

Oldbury Grange 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 3 and 4 May 2016. The visit was unannounced on 3 May 2016 and we told the provider we would return on 4 May 2016. The inspection team consisted of two inspectors, a pharmacist inspector and an 'expert by experience' on day one. Two inspectors and a pharmacist inspector returned on day two. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service.

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 reviewed the information we held about the service. This included information shared with us by the local authority and notifications received from the provider about, for example, safeguarding alerts. A notification is information about important events which the provider is required to send us by law. Prior to our inspection, we were aware of a police investigation into an incident that occurred at the home in February 2016. The investigation is on-going and this inspection did not consider any issues relating to that matter.

Some people who lived at the home were not able to tell us about how they were cared for due to their complex needs. We spent time with them and observed how they received care and support to help us understand the experience of people who, for example due to their advanced dementia, could not talk with us.

We spoke with 12 people and spent time with other people; observing their experiences of living at the home. We spoke with 13 relatives who told us about their experiences of using the service. We spoke with staff on duty including 10 care staff, two nurses, four cooks, one maintenance staff member, one activity staff member, the care co-ordinator, two team leaders, one deputy matron, the matron and the registered manager. We spoke with one of the directors of the provider company who is also a doctor providing GP support to people at the home and one other visiting GP. We spent time with and observed care staff offering care and support in communal areas of the home.

We reviewed a range of records, these included care records for 12 people, seven people's wound and pressure area management plans and 12 people's medicine administration records. We quality assurance audits and feedback from people.

Requires Improvement

Is the service safe?

Our findings

At our inspection in January 2015, we identified a breach in the regulations regarding the provision of safe care and treatment. We found that a lack of cleanliness of both the environment and equipment meant people were at the risk of infection. At this inspection, we looked to see if improvement had been made and found that overall it had.

People told us they felt the home was clean. One person told us, "The girls (staff) come in my bedroom and clean. I'm happy with them." Most areas of the home were odour free, although one bedroom corridor area on the first floor unit for people living with dementia, had an unpleasant odour. One staff member told us, "We'll arrange a deep clean again." Equipment, such as hoists and hoist slings, were clean. We saw one bed rail cover that was cracked and meant it was no longer waterproof and could not effectively be washed. We discussed this with a nurse and they explained the person picked at the bumper cover and it was due to be replaced. Some people had catheters and catheter bag stands placed in plastic bowls on the floor next to their beds so that the risk of infection was minimised because the catheter 'tap' had no contact with the flooring of the bedroom. However, risks of infection were not minimised with the storage of incontinence pads because they were removed from plastic packaging and stored in a cupboard along with staff possessions such as outdoor coats. We discussed this with the manager who told us they would immediately change this practice and ensure incontinence pads were stored in their original packaging.

Food storage areas were clean. However, we saw a block of rat poison was on a saucer on the floor of the dry food store. We discussed this with the manager and they said, "It was put there as a precaution against rodents." The manager agreed that the uncovered block of poison should not be in the dry food store and immediately removed it and arranged for its safe disposal.

At our last inspection in January 2015, we identified a breach in the regulation regarding the provision of sufficient and suitably qualified staff to meet people's needs. For example, we found communal areas were left unattended by staff and risks to people's safety were not managed because there were insufficient staff on shift. At this inspection, we looked to see if improvement had been made and found some had been made but further improvement was required to ensure staff had the skills and knowledge they needed.

We asked people and their relatives about staffing levels and received mixed feedback. Some people told us more staff would mean they did not have to wait for staff to respond to their needs. We discussed this with the manager and they informed us some care staff were new and still getting to know people and the routine.

The manager and matron informed us that whilst there was a continuity of the nursing staff at the home, a number of care staff had recently left. They had recruited to fill the vacancies and new staff were in the process of being trained. The manager said, "We don't want to use agency care workers, so have recruited ten carers, to replace staff, but realise we need to train them so they have the skills they need. I've never before had so many new staff in one go, but we had to replace the leavers." One care staff member told us, "I've only been here six months and don't really know everyone yet myself, so it's really hard at the moment

with all the new staff as they ask me, but I don't always know." Another staff member said, "Improvements are needed in staffing. New staff need to shadow experienced staff and this means everything takes longer."

Most staff said they felt there were enough staff on shift. One staff member said, "I've worked here four years and I'd say staffing levels are pretty good." However, a few staff said they felt more staff were needed at times when people required the most support such as at mealtimes. One staff member told us, "I have spoken to the director about increasing staffing at breakfast and lunchtimes." The manager and director agreed that this was an area identified as a time when extra staffing would be beneficial to support people. The manager said they would look at how shifts were planned, whilst new staff were trained and got to know people to ensure people's safety was maintained and their needs met by staff that knew them. They said they would endeavour to do this.

One person said, "I feel safe here, the girls (staff) are always about. Most staff told us they had completed training to safeguard people from the potential of abuse and staff said they would report any concerns to the manager. A poster was displayed in a communal corridor informing people who to contact if they had any concerns that a person was not safe.

One relative told us, "I feel my family member is safe here but feel they are vulnerable. One day I noticed one resident thumping another resident who was unable to defend themselves. No staff were about; they took five minutes to arrive and stop it." Staff told us that 'most of the time' communal areas of the home were staffed so they could intervene if needed, which we observed. However, where some people's care records described that they had 'aggressive' behaviours, we found no details as to how staff should manage these if the person became anxious or displayed behaviours that may cause themselves or others harm. The manager informed us that training around managing behaviours was planned for and agreed people's care records needed further detail for staff to refer to.

We observed some safe moving and handling practices by staff. For example, two care staff explained to one person that they were going to support them to transfer to a wheelchair. Reassurance was given to the person and staff followed training they had been given in using the hoist. However, one person told us that staff 'lifted them under their arms to help them stand up' which is not safe practice and may cause injury. Whilst we were with one director of the home, we observed some examples of poor practice with moving and handling and pointed this out to them. The director said, "Staff should not do that, clearly further training is needed." The manager showed us planned dates for May 2016 for staff to complete moving and handling training.

Assessments were in place to identify risks to people but risks were not managed consistently by staff because they did not always have the information or training they needed. For example, one person's moving and handling assessment said they needed to use a 'rotunda' to help them safely transfer. However, a review of this person's assessment undertaken by a senior staff member stated this person refused to use the 'rotunda' but no guidance had been given to staff as to how they should safely support this person to transfer. The manager said, "The nurses would know not to lift the person, but with the new staff we have, we agree the records need to be improved on." Another person had received a skin injury because they had removed their bed rail cover and hurt their leg on the bed rail. However, the review of this person's assessment had not considered alternatives such as a low bed with a 'crash mattress' to remove the risk of entrapment and injury from their bed rails. We discussed this with the manager and matron who completed a new assessment of this person.

One care staff member told us, "Some people have bed sores (pressure areas) here but the nurses deal with

those and do the dressings. If we are concerned about someone's skin, we tell the nurse. For example, if I saw a person's skin was red or sore, I'd ask the nurse to come and have a look." The registered manager informed us that seven people had skin damage being treated by nursing staff at the home. We looked at the treatment plans to manage people's damaged skin. We found people had the equipment, such as airwave mattresses, that had been identified as required to reduce pressure on their skin. Nurses had completed training to ensure they had the skills and knowledge they needed to manage people's skin care. People with skin damage, such as pressures areas, had been identified as requiring a 'fortified diet' (food with extra calories added) to promote healing of their wounds. Kitchen staff were able to tell us which people required fortified diets. One care staff member told us, "Some people needed to be checked in their bedrooms and 'turned' (repositioned) every two hours," to minimise pressure on their skin. Records were completed by staff to record when people were re-positioned and were within the timescales identified in people's care plans and risk assessments.

Two people's records showed that their skin damage had increased in severity. A nurse explained reasons for this and told us, "We are following the GP guidance and also best practice with managing skin care and pressure areas." Another nurse told us, "The manager and two nurses completed a tissue viability training day at a local hospital, I feel we have the skills we need to safely manage people's skin and pressures areas." Both nurses told us they felt supported by the manager to maintain their clinical skills. The matron told us, "If we need further guidance we have two GPs we can ask. One is the owner of the home, but another GP also visits at least weekly and provides us with support, such as advising on the most appropriate dressings to use on people's skin damage."

We looked at whether medicines were managed safely in the home. The manager informed us that nurses and team leaders administered people's medicines to them. One nurse told us, "Last year I completed an update in the safe handling of medicines." One team leader said, "I have completed medicines training and have the nurse on shift to ask if I have any queries about people's medicines."

Overall, medicines were stored securely in medicine cabinets in both the treatment rooms and in the medicine trolleys. However, although the medicine trolleys were attended to by staff when medicines were administered to people, we saw prescribed nutritional supplements and medicines that were, on a few occasions, left unattended on top of the medicines trolley whilst the staff member was supporting someone. We discussed this with the matron and they said, "I left one pack of antibiotics out as I am just about to put it back into the medicine fridge. We will be more vigilant about not leaving any medicines on top of the trolley."

Nurses told us that some people had diabetes and they monitored their blood sugar levels. People's diabetes monitoring protocols (plans) lacked detail. For example, they did not record what action nurses should take if a person's blood sugar was too low. However, nurses spoken with demonstrated they had the skills and knowledge to take action if needed.

We looked at 12 people's medicine administration records (MAR) and found they had their prescribed medicines available to them. We found one example where a staff member had signed a person's MAR before giving them their medicines; which meant the record was not accurate at the time we looked at it. We discussed this with the staff member, they told us they had been called to attend an emergency. Otherwise, we found staff signed people's MARs when they had supported and seen people take their tablets.

However, we found nurses and team leaders signed MARs to record that people had taken their prescribed food supplement drinks but had not checked with people or care staff that these had been consumed by people before their MAR was signed. We saw nutritional supplements were left with people to either drink

themselves, or for care staff to support them with drinking. We saw one person had two bottles of food supplement drink on their bedside table. We discussed this with one nurse and they told us they thought one bottle was from yesterday (2 May 2016), this bottle was half full. The new bottle was for 3 May 2016 and remained sealed. However, both bottles were signed for by staff on the person's MAR.

Some people had topical creams prescribed to be applied to their skin. We discussed this with nurses and team leaders and they agreed that they signed people's MARs before checking with care staff that creams had been applied as needed. The manager told us, "We know that we now need to make some improvement with creams and checks to make sure they have been applied to people's skin."

Requires Improvement

Is the service effective?

Our findings

People and their relatives gave positive feedback about the care they received from the nursing staff. One person told us, "The nurses are very good." Nursing staff told us they had completed the training that they needed to effectively meet people's needs. The manager, matron and two nurses had completed MacMillan training so that palliative and end of life care was given to people when required. One nurse told us, "Many people do not wish to go into hospital, they want to stay here and we try to meet their wishes." Care staff felt supported by nursing staff, one carer said, "I worked alongside one nurse and they were amazing."

Care staff told us they received a 'good induction.' People received support from some care staff members that had not completed the training they needed because they had recently started working at the home. One staff member told us, "I've only been here a few weeks, I've got more training to do." Some long standing care staff members needed their skills and knowledge refreshing as we saw some examples of poor care practices. For example, we saw one carer stand over a person to support them with their meal instead of sitting next to them; this practice did not promote a positive mealtime experience for this person.

The home advertises a specialist dementia care unit. However, some practices we observed did not reflect staff having specialist dementia care knowledge. For example, one staff member placed a meal in front a person telling them, 'here's your meal,' the staff member walked away without telling the person what their meal was, or handing cutlery to prompt this person to start their meal. Most staff told us they had completed a basic dementia awareness course. The activities staff member and newer care staff told us they had dementia care training planned. The manager informed us they would look at further developing staff dementia care skills beyond a basic understanding.

Staff told us that supervision meetings were planned for but had not always taken place frequently. The newly appointed care coordinator told us, "Once the new care staff are trained and know people well, the staff supervisions will take place as planned for. Also, I have started to undertake staff observations to check staff have the skills they need. " Staff told us they had team meetings where they could discuss any concerns they had. One staff member said, "Team work is good here. If we have concerns we go to the nurse in charge or team leader."

Staff understood the importance of gaining people's consent and mostly worked within the principles of the Mental Capacity Act. One staff member told us, "Some people with dementia can't consent, but we always explain what we are doing. We don't make people do things." Some staff told us they had completed training about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 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.

The manager understood their responsibilities under the Act. They informed us that three people were deprived of their liberty and they had submitted referrals for a further two people whose mental capacity

was to be assessed. 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 are called the Deprivation of Liberty Safeguards. The manager informed us MCA and DoLS training was scheduled for new staff and for existing staff as a refresher.

Some people's liberty and rights were not restricted unnecessarily. For example, one person wanted to walk along the corridors of the home on their own and we saw staff did not prevent this. However, this was not recorded as a part of the person's risk assessment. Some people's liberty and rights were restricted as they had bed rails attached to their bed and we found an assessment had not always been undertaken to determine the reasons for this. One person told us, "I can't get out of bed in the night to use the toilet because they (staff) have put these sides (bed rails) on the bed." This person told us they had not agreed, or discussed, for the bed rails to be in place and we found no risk assessment to determine why this person had bed rails.

Overall, people told us they enjoyed their meals. One relative told us, "My family member enjoys the food. In four years, they have never criticised it." Another relative said, "I asked staff if they could arrange for my family member to have 'finger foods,' which they did, and this has helped my relative put on weight."

Cooks told us people had a choice of what they wanted to eat on the day when staff served meals. One cook told us, "Care staff should show people two different plated meals to help people choose." However, one person told us, "We get a choice at breakfast but not at lunchtimes." Another person told us, "No, I don't have a choice." We did not observe a meal choice offered to people. We saw a few people did not eat their meal and were not offered an alternative by staff.

We observed the support people were offered from staff during breakfast and lunchtime meals. We found staff did not always prompt or support people when needed. For example, we saw some people had bowls of porridge in front of them but they were not eating and staff were not available to prompt or support people as needed.

Some people's care plans recorded a weight loss and we looked to see how these were managed. One cook told us, "Some people need extra calories so we send snacks for them mid-morning and afternoon on the drinks trolley." We saw such snacks were sent to the units but people were not always given a snack. On the first day of our visit, we saw two people that had been assessed as 'at risk' of malnutrition and had not eaten their lunch. They were not offered high calories snacks in the afternoon. One person's weight recorded a loss of 12 kilograms this year. One staff member on the dementia care unit said, "Because I am quite new, I'm not sure who has to have the snacks."

We discussed with the manager and cooks, our concerns that people may not always be receiving their high calories snacks as planned for. The manager said, "With immediate effect, the cooks will name label snacks so that it is clear who they are for. Newer staff members will be supervised whilst they get to know who people are and as a temporary measure we will have a list with the meal, snacks and drinks trolley to give key information about people's dietary needs. This will include those who need thickener in their drinks as well." On the second day of our visit, we saw this action had been taken and people were given their snacks.

Food and drink recording charts for people identified at risk of becoming malnourished or dehydrated were maintained by staff to monitor how much people had to eat and drink. However, we found that these had not always been completed by staff in sufficient detail to give a true and accurate picture. For example, on the first day of our visit, we saw one person's chart for the previous day (2 May 2016) had gaps where staff had not recorded whether the person had eaten or drunk. Another person's chart recorded they had 500mls

of fluid (drinks) in total on 2 May 2016, which was a very low fluid intake. The chart informed care staff if the total was less than 700mls they should inform nursing staff. However, one nurse said they had not been informed and agreed that staff should have told them. We discussed the incomplete charts with the matron and they said, "I will put a more detailed form in place so that times are also recorded and any offers of food or drink that is declined by people. The senior staff will undertake checks on the charts during the shift to make sure staff are frequently offering and supporting people with food and drink and recording it."

We identified concerns in care plans that people's weight may not have been recorded correctly by staff and found the care plan audit had not identified these. For example, one person's nutritional assessment stated they should be weighed monthly and their Malnutrition Universal Screening Tool (MUST) should be completed. MUST is a management plan for people who are malnourished or at risk of malnutrition. We found that the entries made had not been added correctly so the MUST score was incorrect. We saw another person's weight record that they had put on 10kg in one month. We discussed this with the director of the home, who is a GP, and they agreed this was unlikely and probably a recording error. These potential recording errors meant that people's weight was not effectively being monitored and audits had not identified this issue.

We looked at how people's healthcare needs were supported. One person told us, "If I don't feel well, I tell the staff and they put me on the doctor's list." Care staff told us if they had any concerns about a person's health and wellbeing they informed the nurse. One nurse explained, "Each day we fax a list of people's names that we have health concerns about to the GP surgery. One of the GPs visits people here in the afternoon unless it is more urgent." Relatives we spoke with felt confident that staff requested GP visits when needed for their family member. People's care records recorded GP visits and other healthcare professional visits, such as dental, chiropody and optician visit. Referrals to dieticians and speech and language therapists were made for people when needed. We spoke with both GPs that visited the home; one of the GPs is the owner / director of Oldbury Grange. One GP told us, "The nurses are prompt in referring people who need to be seen by a doctor. In my opinion we are contacted at the right time by staff and this also reduces admissions to hospital."

Good

Is the service caring?

Our findings

People told us staff were kind and caring toward them. One person said, "The carers and nurses are kind. I have no concerns about them." Relatives felt staff had a caring attitude toward people. One relative said, "Staff are caring, some might need a bit more training and sometimes they could do with more staff on a shift, but they do care about people living here." Another relative told us, "The staff were fantastic when my family member first moved here to live. The major plus point here is the staff. They are always cheerful and always happy to help. They are genuine and also ask about us as a family."

Staff described the team as having a 'caring approach' and we saw this over the two days of our visit. The care co-ordinator said, "The care I want to give to people here, is the care I would want to give my mum." Another staff member said, "I've recently started here and I think it is a caring home for people."

We observed kind, respectful and friendly interactions between staff and people living in the home. We heard one person crying out from their bedroom and saw a staff member went to check on the person. We heard this person thank the staff member for coming to them and rearranging their bed covers because they were cold. Some people were not able to use a tissue themselves when needed for their nose or mouth and staff gently supported them with tissues to maintain their dignity.

Most staff that had worked at the home for a longer period of time, knew people and how they liked to be cared for. One staff member told us, "[Person's name] always likes to have a blanket on them, it's not that they are cold but they like to hold it." Another staff member said, [Person's Name] likes to have their soft toy on their lap, it reassures them." Newer staff did not always know what people's needs were but we saw they were trying to get to know people by asking other staff and talking with people.

Staff knew how to maintain people's privacy and dignity such as when supporting people with personal care tasks. One staff member told us, "When providing personal care, I close the bedroom door and make sure the curtains and blind is closed." Most relatives told us their family members were kept clean and were well presented. One relative said, "My family member is always clean, shaved and washed."

A few relatives said they had visited and found their family member had some food spillage on their clothing. We discussed this with staff and one staff member told us, "We do support people to maintain their dignity and keep clothing clean by using aprons at mealtimes. The tabard material ones are best but we don't have enough so have to use the plastic type aprons for some people and these are not as effective. We will tell the manager to order some more tabard material ones and make sure people's clothing is changed if there is a spillage." During our visit we saw at mealtimes people had been provided with tabards and aprons to protect their clothes and dignity.

A few people told us when necessary, they spoke with staff about their care. One person said, "When needed, I talk to staff about my care." One relative told us, "I don't need a scheduled review, I feel I can just pop into the manager's office for an update or to discuss anything needed. If the manager is not there, the nurses always update me and are happy to discuss my family member's care." Another relative said, "We've

never been asked to attend a care review but the senior staff have always said that if we need to discuss anything at any time, just come and ask them." A few people and their relatives said they were not aware of a care review taking place. One nurse told us, "We do try to phone relatives to inform them."

Relatives told us they were able to visit people at any time and there were no restrictions placed on them. One relative said, "We like to visit at lunchtime and can help our family member with their meal." Another relative told us, "I visit at different times and it's never been a problem. Often I might take my family member out somewhere and this is no problem to the staff." Some relatives brought in their pet dogs so that their family member could stroke them. The manager told us, "Relatives can bring in well behaved pets to visit people. It's good for people to see their family dog." A quiet lounge, with tea and coffee making facilities, was available for relatives to use if they wished to spend some quiet time with their family member. During our visit, we saw relatives visit the home and observed good interaction between them and staff.

The provider's complaints policy was shared with people and their relatives. Staff told us that if anyone had a complaint, they would share this with the manager so that it could be looked into.

Requires Improvement

Is the service responsive?

Our findings

A few relatives told us they had met with the manager for an initial care assessment before their family member moved to live at the home. One relative said, "They met with my family member and me at the local hospital and asked us for key information. For example, about their health and what they could do and what they needed support with." A few care records showed relatives had been given an opportunity to complete a 'life history' about their family member which provided information such as previous interests and employment people had worked in. This information meant care staff engaged in meaningful conversations with people, for example about their previous jobs, their children or hobbies. However, other people and their relatives felt they were not involved in planning personalised care and most care records seen did not show how people or their relatives were involved.

One relative told us, "Staff do respond to my family member's needs and do care but it's not at a time when [Person's Name] would prefer. For example, today they are giving my family member a wash at 11.15am and they would prefer a wash early in the morning. I don't know if they were a bit slower because of the new staff or just didn't know." People's care records were not personalised and staff did not always have the information they needed to enable them to respond to people in a person centred way.

One staff member said, "We have a short meeting to tell us about how people are and where we will work for the shift." We observed one meeting which took place in 15 minutes covering all 79 people living at the home. Staff had to listen to the details shared about all 79 people without knowing which people they should focus their attention on because they had not been allocated on the rota to work on a specific unit of the home. The information shared was very brief and did not identify any specific individual needs that staff may need to focus on during their shift. The registered manager informed us that if staff needed more detailed information about people, this would be given and the meeting would be longer.

Some staff knew how to respond to people's needs. One person told us, "I've been waiting to have a shower. The staff have gone." We saw one staff member responded to this person and reassured them that they had needed to deal with an emergency but were now able to support them with their shower. Other newer staff members told us they did not really know people well enough yet to fully respond to their needs but if they had any concerns about them, such as health issues, they would ask the nurse. The nurses demonstrated a knowledge of people's health needs, such as diabetes, and how they would respond to any concerns raised to them by people or care staff.

On the first day of our visit, one person told us, "The call bells are not working. I've complained about it. I'm worried in case I need help to get to the toilet." We saw all the call bell lights were red and discussed this with a nurse, they told us, "The system has recently broken and a part has been ordered. The call bell system will fixed tomorrow. In the meantime, staff are checking people in their bedrooms every hour or so." We saw that this happened on the second day of our visit, the call bell system was repaired. However, we found people did not always have access to their call bell.

We went to speak with one person who was cared for in bed and found their call bell on the floor behind

their bed. This person told us, "Most staff are good and make sure I've got my call bell, but some forget and don't give it to me. Then, I have to wait until someone comes along."

One person had a fall and staff promptly responded to them by checking for any serious injury and offering reassurance. They explained to this person that they would help them to bed for a lie down and ask the doctor to visit to check them. However, we found this person was left in bed, following a fall, without their call bell. We discussed our concerns about this with the manager and they told us, "Staff will check every so often on them, but they should have their call bell really." We saw some people did not have cords attached to their call bell point in their bedrooms and would not be able to gain staff attention if needed. We asked the manager about this and they informed us, "Some people might not be able to use a call bell cord and for a few people it might be a safety hazard." However, we found no assessment or reasons for these people not having a cord attached to their call bell point in their care records and no action had been taken to consider how these people, some of whom were identified to be at risk of falls, would gain staff attention if needed without access to a call bell.

One relative told us, "Sometimes there are no staff in the lounge where residents are." Another relative said, "I see people in the lounge that need attention, but they don't get it because staff are not always in there." Although communal areas had call bell points, we found no cords were attached to them to enable people to use them if they needed staff. We pointed this out to the director of the home and they asked one staff member to attach a cord. The manager informed us, "Most of the time staff are present or close to all the communal areas," and we observed this during our two day visit.

We looked at how people spent their time in the home and saw some people independently pursued interests and hobbies. One person told us, "I enjoy completing adult colouring books, they are relaxing and I'm happy with those." Another person said, "I'm happy with my television and watching the quiz shows." One relative told us, "The home owners have set up a little shop that sells things like packets of crisps. My family member, when they are well enough, helps run the shop which they enjoy doing."

Many people who lived at the home needed support to take part in activities and depended on staff to prevent them becoming socially isolated. There was a designated activities staff member and they told us, "I started here in December 2015 and work five hours daily during weekdays. I alternate my days between the different floors of the home and try to offer group activities and also when possible spend time with people who are cared for in their bedrooms." We asked this staff member if this was sufficient time and they told us they did their best and care staff also tried to offer activities when possible, but more time would improve social activities offered. People and their relatives told us that a barge trip had taken place, Easter bonnets had been made by some people and there were local links with a ukulele band that visited to play instruments to people. The activities staff member did not have specialist knowledge about activity provision for people living with dementia. However, we saw the provider had painted bedroom doors in different colours on the dementia care unit and had pictures to promote reminiscence to help people orientate themselves. The manager informed us that further training focused on the care of people living with dementia was planned for.

We asked people and relatives about what they would do if they wanted to raise a concern or were unhappy about an aspect of the home. People and their relatives told us they would speak to staff or the manager if they felt they needed to. Most people told us they had no current concerns or complaints. One relative said, "I once mentioned about the cleaning and the next day it had improved." Another relative told us, "I was concerned about my family member being left alone in their bedroom during the daytime and once I had raised this staff acted on it to encourage them in to the lounge." One relative told us they had raised concern about their relative's bedroom and felt issues had not been resolved. We discussed this with the manager

and they told us, "I have not logged the details, I should have recorded the details, but I am aware of the concern." They explained to us the action they had taken, and that they would discuss this further with the family.

We asked relatives if they were given the opportunity to provide feedback about the way the home was run. One relative told us, "I went to a relative meeting after Christmas 2015 and I was the only one there." Most relatives told us they were not aware of these meetings and had not been asked for their feedback through a survey questionnaire. Whilst the manager informed us that relative meetings were planned for and took place, we found they were not always effectively communicated to people's relatives.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was supported by a matron and a deputy matron and a new care coordinator had started in April 2016. At our previous inspection in January 2015, we had found that the overall governance process was disjointed with no one person having a complete overview of the service. At this inspection, we found some improvement had been made, such as asking for people's feedback on the service they received. The improvement made meant the home was no longer in breach of the regulations.

Since our last inspection the provider had added an extension to the home to increase the number of people who lived there. The provider had followed the appropriate guidance with us to increase the number of beds the home offered.

The manager had introduced two new posts of team leader for each floor. The matron informed us, "The owner, who is one of the GPs that visits people here, has also become more involved in the home. There is a planned management meeting every Wednesday. They listen to what is said." We discussed the management structure with the manager and matron and the matron told us, "Things have improved, but there is room for further improvement. We, and the nurses, will have designated tasks such as who checks people's charts are completed each shift. This will help on a day to day basis and make sure things are completed as they should be."

The home was not displaying their previous inspection rating of 'Requires improvement,' and we found it was not on the provider's website information. The regulation for a provider to display their inspection rating, which came into force on 1 April 2015, says that providers must 'conspicuously' and 'legibly' display their CQC rating at their premises and on their website. We discussed this with the manager and director they told us they were unaware of the regulation. The manager was unsuccessful in their attempt to download a ratings display poster during our visit and told us, "I will get some I.T help and make sure we display what we need to." The manager sent us other statutory notifications that they were required to send, telling us about specific events that occurred at the home.

On day one of our visit, the manager and matron informed us that whilst there was a continuity of the nursing staff at the home, a number of care staff had recently left. We were told there was a new cook and 10 new care staff. We discussed the reasons for this turnover of staff and were told some had chosen to leave to work elsewhere but the manager had needed to discuss poor working attitudes with a few care staff who had decided to leave at short notice. This showed that the manager had addressed working practices that were not caring.

The manager recognised that the recent care staff recruitment meant that some staff did not yet have all the skills and knowledge they needed to fully meet people's needs. However, training was planned for and nurses and team leaders were on shift to provide support, supervision and guidance to new staff.

The provider had a process to assess the quality of the service provided. We found effective audits of infection control, pressure care, environmental health and safety and fire safety audits. However, we found

some audits were not always effective. For example, checks had not identified that people did not always have access to their call bell. The care plan audit completed in March 2016 that actions were needed to improve the information about people's care and support needs. However, the audit had not identified some issues that we found, where people's risk assessments did not give staff the information they needed when supporting people with transfers and had not identified when errors had been made in logging people's weights. We identified that improvement was needed by staff in completing food and fluid charts.

Medicines audits were completed but had not identified improvement was required in the information in people's as needed (PRN) medicine guidance or in the way nurses' ensured care staff had supported people to consume their prescribed food or drink supplements that nurses had signed for.

Accidents and incidents were recorded and some analysis took place. However, we found consideration had not always been given to prevent reoccurrence of accidents. For example, one person had a skin injury from bed rails but alternatives to this person having the bed rails in place had not been considered as a part of the analysis. The matron told us the number of falls people had in the home had reduced since they had informed staff they should ensure, as far as possible, that a staff member remained in the communal areas of the home and records shown to us reflected this.

Some people and relatives told us that their feedback was not sought from the provider and the manager explained they did group surveys and said they had sent 32 satisfaction surveys to people and their relatives in January 2016. The results of the survey had been analysed showing 88.2% of people included in the survey were satisfied with the service; with most people rating the service 'very good'. Comments included, "I cannot fault anybody and you are all very caring and I cannot be happier." We found some people and their relatives had not been given the opportunity to give feedback at this time and felt they would have wanted to be included in the survey.

Staff told us they felt supported and worked well as a team. Staff knew the different roles of senior staff and said they felt they were approachable. One staff member told us, "I definitely get management support." Over the course of our two day visit, we identified some issues such as poor moving and handling practices and people's food and fluid charts that had not been completed. We discussed these issues with the matron and manager who agreed the issues needed improvement and took responsibility for the findings. We found there was no blame culture at the home. Instead, where improvement was needed, this was noted and actions agreed by senior staff and management to implement improvement.

Following our inspection visit, we received an action plan from the matron and manager telling us what actions had, and were, being implemented in response to our feedback to them so that improvement was implemented straight away.