Somerset Care Limited

Polars

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 & 22 April 2016 and was unannounced. The home provides accommodation for up to 37 people, including some people living with dementia care needs. There were 27 people living at the home when we visited. The home was based on two floors connected by stairs and two passenger lifts; there was a choice of communal spaces where people were able to socialise; and most bedrooms had en-suite facilities.

At the time of the inspection there was no registered manager in place. A manager from one of the provider's other homes was managing Polars on a temporary basis. The provider was in the process of recruiting a permanent manager who would then apply to be registered with CQC. 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.

At our last inspection, in November 2015, we told the provider to take action to make improvements in relation to the levels of staffing and the support staff received; the management of risks to people; infection control arrangements; the management of medicines; and quality assurance processes. We took enforcement action and required the provider to make improvements by 31 January 2016.

At this inspection we found improvements had been made, but the provider was still not meeting all fundamental standards of safety and quality and there was a lack of consistency in the management of the home.

Infection control arrangements were not adequate. The laundry was not clean and hygienic, although plans were in place to refurbish it; boxes used to store topical creams were not clean and posed a risk of cross contamination; and not all staff were aware of people with an infection that required additional precautions to be taken when supporting them.

People's blood sugar levels were being monitored more regularly, but action was not always taken when they were found to be outside the normal range. One person was not supported to use their walking frame, which contributed to them falling. However, other risks to people were managed appropriately and without restricting people's freedom.

People had mixed views about whether there were enough staff to support them in a timely way and the process used to calculate staffing levels was not robust.

Staff sought verbal consent from people before providing care and support. However, decisions made on behalf of people were not always recorded in accordance with legislation designed to protect people's rights.

People received personalised care from staff who understood and met their needs well. However, information about the support they needed was not always available as care plans were being transferred to a computerised system.

People felt safe at Polars and staff knew how to protect people from the risk of abuse. Arrangements were in place to keep people safe in the event of fire. Medicines were managed safely and people received them when needed. Recruitment procedures helped ensure that only suitable staff were employed.

Staff were knowledgeable about the needs of people and how to care for them effectively. They received appropriate training and were supported in their work.

People had a choice of suitably nutritious food and were encouraged to drink often. They were supported to access healthcare services when needed and their relatives were kept up to date with any changes in their health.

Staff treated people with kindness and compassion and had built positive relationships with them. People's privacy was protected and they were involved in planning the care and support they received.

People were supported to make day to day choices and were encouraged to remain as independent as possible. They had access to a wide range of activities tailored to their interests. The provider sought and acted on feedback from people and a suitable complaints procedure was in place.

The home had an open and transparent culture. Visitors were welcomed and the provider notified CQC of all significant events. Quality assurance systems had improved and had led to improvements being made. A development plan was in place to further improve the service.

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.

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.

Not all staff were aware of people who presented a high risk of infection. The laundry was not fit for purpose and was awaiting refurbishment.

The risks of people falling were not always managed effectively; staff did not always take action when people's blood sugar levels exceeded their normal range.

People and staff had mixed views about whether there were enough staff to support people. The arrangements for setting staffing levels were not robust.

Medicines were managed safely and people felt safe at the home. Safe recruitment practices were followed and arrangements were in place to keep people safe in an emergency.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider's policy did not always follow legislation designed to protect people's right.

Staff were suitably trained and supported. They were knowledgeable about people's needs.

People received enough to eat and drink and staff created a pleasant mealtime experience for them.

People were supported to access healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff interacted positively with people and built caring relationships with them.

People's privacy was protected and they were treated with dignity and respect.

People were involved in planning their care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some information about the support people needed was not available to staff as it was being transferred to a computer-based system.

People received personalised care from staff who knew them well. People were supported to make choices and remain as independent as possible.

A broad range of appropriate activities was available.

The provider sought and acted on feedback from people. There was a suitable complaints policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in place. There was a lack of consistency in the management of the home, although a permanent manager was being recruited.

There was an open and transparent culture at the home and visitors were welcomed.

Staff understood their roles and worked well as a team.

There was a development plan in place to improve the service and quality assurance processes had helped identify and address concerns.

Polars

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 19 & 22 April 2016 and was unannounced. It was conducted by two inspectors and an expert by experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed 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 10 people living at the home and six family members. We also spoke with the manager, the deputy manager, seven care staff, a member of kitchen staff, a member of the maintenance team and the activities coordinator. We obtained feedback from two community nurses who have regular contact with the home. On the second day of the inspection we met and spoke with the provider's Operations Manager.

We looked at parts of care plans and associated records for 12 people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, quality assurance records and the provider's policies. We also observed care and support being delivered in communal areas.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection, in November 2015, we identified that risks to people's safety were not managed appropriately, there were not enough staff deployed, medicines were not managed safely and infection control arrangements were not effective. At this inspection we found improvements had been made but infection control arrangements were still not adequate.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. These include the need to complete an annual statement for each home detailing outbreaks of infection, audits undertaken, risk assessments, policies and staff training. The provider produced an annual statement covering all of their homes collectively, but this did not reflect the effectiveness of infection control arrangements at Polars.

Infection control risk assessments had been completed. These had identified that three people had an infection that was resistant to most antibiotics. Their care plans included clear guidance to staff about how to prevent the spread of this infection by taking particular precautions when providing care and support and washing their clothes and bedding separately. However, not all staff knew which people carried this infection and two staff members told us they took no additional precautions when supporting these people. This put other people at risk of acquiring the infection through cross contamination.

Topical creams for people were kept together in three storage boxes. We had previously identified that these were not clean or hygienic. Whilst some improvements had been made and cream applicators were kept separately from the topical creams, we noted the boxes where the creams were stored were smeared with the residue of various creams that had leaked out of their tubes. As the boxes contained multiple creams for different people, so this posed a continuing risk of cross contamination to people.

The laundry room, which was accessed via an outside courtyard, did not have a door in place and therefore dust and dirt from outside had blown inside. The room was not clean and was cluttered with a discarded pallet, used mats and basins. Paint was peeling from the window fame and sill, which meant they could not be cleaned effectively. There was no dedicated hand washing sink, so staff said they had to use one of the sluice sinks to wash their hands, which were also being used to soak mop heads at the time of our inspection. Infection control guidance provided by the Department of Health recommends that sluices are not housed in laundries as they present a risk of cross contamination through splashing. There was no clear process in place to ensure that items being sluiced, or dirty items entering the laundry, could not contaminate items that had been cleaned. The laundry room was not a hygienic environment to launder linen and people's clothing. The Operations Manager told us plans were in place to refurbish the laundry in the near future, but this work had not been started.

The failure to ensure infection risks were managed effectively was a breach of Regulation 12(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other areas of the home were clean and hygienic, and checks were conducted to monitor the cleanliness of the home. One person described the home as "spotlessly clean".

At our last inspection we found staff did not monitor people's blood sugar levels regularly. At this inspection we found these were monitored regularly and guidance was available about each person's blood sugar levels. However, staff did not always take action when the levels went outside of the person's normal range. One person's normal blood sugar range, on a nationally used scale, was recorded as between 4 and 10. On one occasion, when it was recorded as 12.6, staff called 111 for advice. A staff member said they would have monitored the person's levels every two hours until the blood sugar level decreased; however, there were no records of this so the provider was unable to confirm that this had been done. Another person's normal range was also recorded as between 4 and 10 on the scale. When their blood sugar level was recorded at 13.9, staff did not seek medical advice, but took a further reading two hours later, when they found it had increased to 14.1. A senior staff member said medical advice should have been sought, as the blood sugar level was not going down. However, this was not done and staff did not check the person's blood sugar level for a further five hours; by this time it had reduced and was within the person's normal range. There were no records available to show whether the person's health had been monitored during this time to identify signs of them becoming unwell.

Clear procedures had been put in place since the last inspection to reduce the risks of people falling. Risk assessments were reviewed after each fall, and after three falls, the person was referred to their GP, and the falls clinic, so additional safety measures could be considered.
However, we identified that one person had not been supported to use a walking frame they had been given prior to moving to the home in January 2016. They subsequently had three falls and were referred to the falls clinic, who instructed staff to support the person to use their frame. A senior staff member said, "We [initially] identified [the person] was more at risk with it, so we took it away. We are now encouraging [the person] to use it slowly". They had not documented the reasons for taking away the person's walking frame and had not sought advice from specialists before doing so.

In one person's room we saw the cord from their call bell was stretched across the bed to the chair in which they were sat; this caused a trip hazard. The person told us "Every time I get up I end up with the cable wrapped round my legs; it's quite dangerous. We drew this to the attention of the manager who explained that staff should have given the person a pendant alarm to wear around their neck and the cord should only be used when the person was in bed. They then moved the cord to a safe place.

The failure to mitigate health and safety risks to people was a breach of regulation 12(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An appropriate system was in place to assess and analyse accidents and incidents across the home and action was taken to learn lessons from them and reduce the likelihood of recurrence.

Staff supported other people to minimise risks to people without restricting their independence. For example, advice about a medicine that one person was taking advised against taking alcohol with it. However, the person enjoyed drinking wine. They had been made aware of the risks and decided to continue drinking a small quantity of wine each day. Staff supported them to do this while monitoring them for any signs of an adverse reaction.

The risks of people developing pressure injuries was managed effectively. A nationally recognised tool was used to assess people's individual risk and staff knew what action to take to mitigate the risks. A community nurse confirmed that staff sought and acted on their advice when needed, and managed pressure injury

risks appropriately.

Most people told us there were usually enough staff to meet their needs and call bells were responded to promptly. However, some people reported delays in the mornings. For example, one person told us, "In the mornings I ring my bell and I might have to wait about three quarters of an hour before they can get me up." A relative told us, "One [staff member] normally responds quickly, but then has to find a second [staff member] and the hoist, so that's what takes the time."

The manager told us they aimed to have five care staff, a shift leader and a senior staff member on duty for each day shift. The staff rotas for the week of the inspection and the week before the inspection showed this was not always achieved; on some shifts only four care staff were scheduled to work which meant fewer staff were available to support people. The manager told us they had recruited three additional care staff members, who were due to start work in the near future. They said this would enable them to make sure there were always five care staff on duty. Night duty staffing levels had been increased from two care staff to three care staff who remained awake all night.

A new staffing rota had recently been introduced at the home. Staff had mixed views about the staffing levels. A staff member told us "Since we have increased numbers [of staff] it's perfect. We have time to sit with people and chat." Another said, "Staff are very flexible; and we get extra staff in when people are very poorly." However, other staff were less positive. For example, one told us, "With full staff, [the home] runs better, but most of the time it's not five staff [on duty], it's usually only four; it sometimes gets quite stressful. We never have time to sit with people."

Following the last inspection, the provider had decided not to admit any new people to the home, in order to give them time to address the concerns we identified. When setting staffing levels, the manager and the Operations Manager said they would take account of information in people's care plans, call bell response times and safeguarding incidents. In addition, before admitting any new people they said they would assess whether they needed more staff to meet the person's needs. However, they were not clear about how they would do this in practice and did not use a staffing tool to help calculate staffing needs. The process was not robust and they were not able to confirm how they would make sure there would always be enough staff to support people appropriately.

People felt safe living at the home. One person told us, "It's the staff that makes me feel safe." Staff knew how to identify safeguarding concerns and acted on these to keep people safe. We viewed examples of referrals staff had made to the local safeguarding authority, together with investigations competed by the provider. These were thorough and had been completed promptly. A care staff member said, "We look for signs that [people] are acting differently; like if they become inward and quiet."

The arrangements for obtaining, storing, administering and disposing of medicines received into the home had improved and the provider had updated their policy since the last inspection. Clear guidance had been developed to help staff know when to administer 'as required' medicines, such as pain relief and medicines to help reduce people's anxiety. Medication administration records (MAR) contained no gaps and confirmed that people had received their medicines as prescribed. One person self-administered one of their medicines; an appropriate risk assessment had been completed for this and they were able to store the medicine safely.

We observed part of the medicines round and saw staff followed best practice guidance by administering and recording medicines to people individually. Staff administering medicines had received additional training and had had their competency re-assessed. In addition, the manager had introduced a new

procedure when administration errors were identified. It required the staff member to reflect on what went wrong and to identify learning for the future. The manager gave an example of how this had been used to improve staff confidence and competence.

Clear recruitment procedures were in place to help ensure staff were suitable to work at the home. These included reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home.

There were arrangements in place to keep people safe in an emergency; staff understood these and knew where to access the information. Personal emergency evacuation plans were available for all people; they included details of the support each person would need if they had to be evacuated and these were kept in an accessible place. Fire safety equipment was tested regularly and staff had received training in first aid. All but one of the external doors were alarmed, so staff would be alerted if people left the building unaccompanied. We brought the unalarmed door to the attention of the manager, who took immediate action to make it secure.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, in November 2015, we identified that staff did not receive appropriate training and support, and were not clear about legislation designed to protect people's rights. At this inspection we found staff training had improved, but the provider's policy did not always follow the requirements of the Mental Capacity Act, 2005 (MCA).

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

Decisions made on behalf of people were not always recorded in accordance with the MCA. Some people living at the home had a cognitive impairment and care records showed they were not able to give valid consent to certain decisions. The provider's policy only required staff to make best interests decisions on behalf of people where these related to the use of restraint, such as bed rails; the use of monitoring equipment, such as pressure alert mats; or the administration of medicines covertly, for example by hiding them in people's food. For other decisions, such as delivering personal care, using continence products on people, or administering medicines in an open way, the provider did not require staff to make best interests decisions. They relied on staff obtaining implied consent from people; for example, by people accepting medicines that were offered. This assumed that people understood the purpose of the medicine and were able to weigh up the benefits compared to the disadvantages posed by the side effects. The manager told us they assumed everyone had capacity to make decisions unless they saw evidence to the contrary.

Information in the care records of two people indicated they lacked the capacity to make important decisions, yet staff had not assessed their ability to make decisions about the care and support they needed. They were administering medicines to them, but had not checked that the person understood why they were taking them or whether they were able to weigh up the benefits. Staff had not consulted family members for their views. Therefore, the provider was unable to confirm that it was in these people's best interests to receive the medicines.

The monthly care reviews for another person had been signed by them up to January 2015. Entries since that date indicated the person was no longer able to make important decisions. The provider was not able to confirm that the care and support they had delivered to the person since January 2015 had been provided with their consent or was in their best interests.

One person's assessment concluded that they had capacity to agree to the use of a pressure alert mat to monitor their movements. The consent form for the use of this equipment had been signed by the person's relative, although staff had not checked that the person had consented for their relative to act on their behalf.

The failure to follow the Mental Capacity Act, 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to consent to their care and support were invited to sign their care plans each month when they were reviewed. This showed they had been consulted and were in agreement with their plan of care. Staff sought verbal consent from people before providing care and understood that some people needed to be given time to process information and respond. For example, care plans contained information such as "Has full capacity to make decisions. Can communicate needs, though slowly".

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 (DoLS). We checked whether the service was working within the principles of this aspect of the MCA and found it was. Two people had been made subject of a DoLS authorisations and applications had been made for a further four people. However, not all staff were aware of the people who were subject to DoLS. In addition, a senior member of staff told us one person was subject to DoLS when they were not. Staff said they would not allow people to leave the home unaccompanied. One staff member said, "I would encourage them not to leave and distract them by suggesting other activities." We discussed this with the manager who provided clarification for staff.

Staff were knowledgeable about the needs of people and how to care for them effectively. One person told us, "We're looked after so well and they will help you with anything, you can just mention it." Another person said of the staff, "They don't just know what they're doing, but you can see they're genuinely interested." Feedback provided by a GP who had regular contact with the home stated, "I've always been impressed with the friendliness and courtesy of staff and the quality of care delivered."

New staff followed a comprehensive induction programme in line with the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. They worked alongside a more experienced member of staff, who acted as a mentor, until they had been assessed as competent to work unsupervised.

Additional training had been provided to staff since the last inspection and one staff member told us they had recently had "too much!" training. Records of staff training were not organised well, but an updated copy of the staff training records confirmed that all staff were up to date with the provider's mandatory training programme. The manager told us they had achieved this by implementing a more robust approach to staff who did not attend training, in line with the provider's discipline policy. Staff training was effective. For example, we saw staff supporting people to move around the home using appropriate techniques, and staff were able to communicate with people appropriately.

People were cared for by staff who were appropriately supported in their work. Staff received regular supervisions with a manager. Supervisions provide an opportunity for managers to meet with staff, feedback on their work, identify any concerns, offer support, and discuss training needs. Staff told us they felt "supported" by managers and described supervisions as "useful". In addition, staff told us their received annual appraisals which provided feedback on their performance.

People were satisfied with the quality of the food. They could choose from two menu options; some had made their choice the day before and some were offered a choice at the point of service. This was particularly helpful for people living with dementia, who may not have remembered what they had ordered. Staff checked people were happy with their choices and supported people to eat when needed, for example by quietly prompting them or cutting up their food when asked.

The dining room was laid out in the style of an old-fashioned tea room with lace table cloths, flowers, condiments, serviettes and glasses. People could choose where they sat and the group they sat with. Staff wore vintage aprons and on each table was a reminiscence sheet with 'news from yesteryears'. This helped promote conversations between people while waiting for their meals and created a relaxed and pleasant experience for them.

People had access to drinks throughout the day and most people said they were encouraged to drink often. One person told us staff "take it as important that you drink." The manager said they had introduced a 'late supper' for people who preferred to eat later and introduced a 'caring menu' designed by nutritionists. Records showed people's weight was monitored regularly and action was taken if unplanned weight loss was identified, for example by referring them to their GP.

People were supported to access other healthcare services when needed and they were seen regularly by doctors, nurses, opticians and chiropodists. One person had recently lost a set of dentures and we saw a dentist had been requested to visit the person. Staff told us they enjoyed good working relations with community nurses. This was confirmed by a community nurse, who told us, "We have a good rapport. They take our advice, are always available to see us and we're made welcome." A family member provided examples of when medical help was sought quickly when their relative had not been well. They said, "I thought it was handled well", and added that concerns were "acted on straight away".

Good

Is the service caring?

Our findings

At our last inspection, in November 2015, we identified that not all staff were sensitive to people's needs. At this inspection we found all staff treated people with kindness and compassion.

One person said of the staff, "They're really good here; they're really caring." Another person said, "Thank goodness they're there. These people are so kind nothing's too much trouble and they look after you so well." A family member told us "[My relative] was unsettled when they first arrived; [staff] spent a lot of time reassuring her, and being with her, and talking to her." Another family member described staff as "friendly and helpful".

Most people told us they had a good relationship with staff. They were clearly relaxed and comfortable in each other's company and related to each other in a positive way. Staff knew people's backgrounds and had formed positive relationships with them. One person said, "There's no problem in telling them anything." Another told us, "All the staff know me well and look after me how I want." A further person said, "We have good banter. I tease them and they tease me." When a staff member told the person they would be "back in two minutes" to support the person with their bath, the person said, "I'll time you" and both laughed. Another person told a staff member, "You forgot my cup of tea earlier." The staff member was very apologetic and offered to make the person one straight away; they put their arm around the person, who clearly appreciated the response, and they both laughed about it.

All the interactions we observed between people and staff were positive and people told us staff knew them very well. When medicines were being given, staff checked people were happy to receive them and explained what they were for. Before the fire alarm was tested, staff warned people about this and were available to support them if they became upset by the noise. Before providing support to people, staff checked people were ready. For example, we heard a staff member say, "We're just going to help you up now to go to the dining area. Is that alright? Are you happy to go?"

Staff did not rush when providing care. When people wished to self-mobilise around the home, staff encouraged them to travel slowly and at the own pace. When using equipment to support people to move, staff checked people were ready to move, gently reminded them to lift their feet up and made sure they were comfortable throughout the process. When people were sat in arm chairs, staff knelt down to engage with them at eye level and used touch appropriately to reassure them when they became anxious. We frequently heard comments such as "Would you like a cushion under your arm?" "Are you warm enough?" "Shall I put this here so you can reach it?" When one person looked restless, a staff member spent time trying to ascertain their needs. When the person did not respond, they gently made suggestions until the person answered "yes" to needing the bathroom. The staff member then supported them to visit the bathroom.

People's privacy was protected. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. A staff member told us, "You have to remember it's their home." A quiet area was available where people could meet and talk to visitors in private. Confidential care

records were kept securely and only accessed by staff authorised to view them.

People could choose the gender of the staff member, or request particular staff members, to support them with personal care. One person said, "I don't mind male or female, but I have preferred carers who I do not want to provide care and the seniors are aware." Another person told us, "I'm happy with all staff, but there's one I [choose not to have]."

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going as part of the monthly review process, which people were invited to sign. Family members told us they were always kept up to date with any changes to the health of their relatives.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, in November 2015, we identified that people's care plans were not up to date and did not cover all their care needs. At this inspection, we found improvements had been made but care plans did not always support the delivery of individualised care.

The care plans were being transferred from a paper system to a computer-based system. The process had been started before the last inspection and was still on-going. The manager told us the end result would be more up to date, comprehensive, care plans that would enable staff to provide more personalised care. However, it meant staff did not always have access to key information to enable to support people appropriately.

For example, records of monthly reviews of people's care were not always available. The assessment and review of a person's mobility could not be found, so staff were unable to confirm the rationale for changing their support arrangements. Information about the frequency of checks needed for a person who spent most of the day in their room was not available, nor was guidance about how staff should monitor the person for signs of hypoglycaemia (low blood-sugar levels). Staff told us another person had a GP care plan for "shortness of breath". This could not be found, although staff were clear about the support the person needed. The lack of information meant people may not have received consistent care and support from all staff.

Other care plans provided very clear guidance to staff about how people preferred to receive care and support. For example, one person's plan detailed their night time routine and how they liked staff to check them in the night so that they did not wake them.

When we spoke with staff, they demonstrated a good awareness of people's individual support needs and how they preferred to receive care and support. For example, they knew how often people liked to bathe, whether they preferred a bath or a shower, and what support they needed to dress. They knew what medicines people were taking, why they were taking them and how they liked to receive them. They understood people's individual dietary needs and where people liked to take their meals.

People confirmed they received personalised care from staff who understood and met their needs well. One person told us staff knew they liked to take a leisurely bath. They said, "[Staff] let me have a soak, which is nice." Another person told us, "I've lived life to the full and you wouldn't get a better place [than Polars]. You get marvellous treatment here." A family member said, "[My relative] was in hospital recently and very much talked about looking forward to coming home; she sees [Polars] as her home now."

People were encouraged to remain as independent as possible and staff told us people were given complete choice about how they spent their days. A person told us, "I can come and go as I want. I just let [staff] know where I am and where I'm going so they don't worry." Another person said, "[Staff] don't tell you what to do or where you have to be; it's all up to you." Staff asked people where they wished to take their meals, where they wanted their drinks, and where they wished to spend their time. A staff member said,

"People have complete choice. If they want to go back to bed [after breakfast], they can." Another staff member told us, "We don't get people up [in the morning] unless they want to. We all work like that. We sometimes run late with breakfasts, but so what? If [people] want breakfast late, they can." Another staff member described how they encouraged people to choose their clothes by making suggestions and getting a selection of clothes out for the person to choose from. They said, "We always give [people] a chance to make the choice themselves."

Reviews of people's care were conducted monthly by key workers, or when people's needs changed. A key worker is a member of staff who is responsible for working with certain people, taking responsibility for planning that person's care and liaising with family members. People and their relatives were consulted as part of the review process and their views recorded. As people's needs changed, most care plans were developed to ensure they reflected people's current needs.

A broad range of activities was provided throughout the week and was advertised on the home's notice board. They had been tailored to meet people's individual needs and staff described how they continually reviewed and developed activities by seeking feedback from people. These included singing, games and quizzes. People were engaged with knitting, drawing or chatting in groups. One person told us, "[Staff] do work hard to keep us occupied." Another person said, "You can join in or you can do as you please; some of us do our own thing."

The activity coordinator was skilled in supporting people to reminisce. For example, during preparations for an activity to celebrate the Queen's birthday, one person said they would like Battenburg cake. This led to a discussion about a royal family of the same name with links to the Isle of Wight. When discussing songs for an external entertainer to sing, the activity coordinator showed a good understanding of people's likes and dislikes and was clear that the music should be chosen by people rather than by the entertainer. Some people preferred to remain in their rooms, rather than take part in group activities, so the activity coordinator spent time with them on a one-to-one basis. In addition, care staff conducted hourly visits of people in their rooms to reduce the risk of social isolation.

The provider sought and acted on feedback from people through a range of methods. People told us 'residents meetings' were held, although these were not always well attended. One person said, "[Staff] are very happy for you to approach them so they can put things right. They really would rather know than not, definitely." The provider also conducted annual questionnaire surveys of people, families and professionals. The manager told us the results from last year's survey had not been "followed through" as the previous manager had left. However, they were planning to conduct a new survey in the near future and described how it would be used to improve and develop the service for people.

The provider conducted telephone surveys with five percent of people's closest family members each month. Results showed they were fully satisfied with the care being provided to their relatives. In addition, senior managers conducted a series of 'themed conversations' with a sample of people each month to ascertain their experience of being cared for at Polars and to identify any improvements that could be made. One person commented in the survey that they were always left until last to be supported to transfer back to the lounge after lunch. When we spoke to the person, they said this had improved since the survey. They said, "They take me in the middle now. I'm not the first, but they don't leave me til last." Feedback from another person indicated they would like to do some gardening and we saw this was being arranged.

People were given information about how to make complaints and this was also displayed in the reception area of the home. People confirmed they knew how to make a complaint and said if they had any concerns they would speak with senior staff. One person told us, "I do tell people if I'm not happy." Complaints

received by the service were dealt with in a timely manner and in line with the provider's complaints policy.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, in November 2015, we identified a lack of support from the provider, which had led to the previous registered manager having to cover care shifts; and quality assurance processes were not always effective. At this inspection, we found the provider was actively supporting the home and quality assurance processes had improved. However, there was a lack of consistency in the management of the home.

The previous registered manager left the home shortly after the last inspection. The provider had appointed an interim manager, but they had left the home two weeks before this inspection took place. A registered manager from one of the provider's other homes had been deployed to Polars until a permanent replacement could be recruited and registered with CQC. Staff told us the home was being run more effectively, although the inconsistency of managers had unsettled them. A staff member said, "We need a [permanent] manager. The interim managers keep going." Another staff member told us, "The routine keeps changing as new managers come in and it's unsettling for [staff and people]." To provide a degree of continuity of management support, the provider's Operations Manager was visiting the home on a weekly basis.

Managers employed by the provider were encouraged to keep up to date with best practice guidance by gaining additional qualifications and by meeting other managers at regional events. The manager told us "The [arrangements] have worked well. You have someone to talk to who is outside the home; you don't feel so alone."

There was a development plan in place to improve the service. One element of this was the introduction of a new staff rota, which the current manager had just implemented and described as their "biggest challenge". They had also introduced a new role of 'shift leader'. The changes were designed to increase staffing levels, reduce staff absence and provide additional support to senior staff. The changes also clarified and enhanced the staffing structure, which consisted of a manager, a deputy manager, senior staff, shift leaders and care staff. However, these needed time to become embedded in practice.

There was an open, transparent culture in the home. The provider notified CQC of all significant events, the rating from the previous inspection report was displayed in the reception area and on the provider's website. Visitors could visit at any time and were made welcome. The development plan was based on the previous CQC inspection report and the concerns identified in the warning notice we issued after the last inspection. The provider had taken the decision not to admit any new people to the home until identified improvements had been implemented. This showed an acceptance of the concerns and a willingness to improve the service for the benefit of people. The manager told us, "I run an open culture. The residents should be running the home and we should make it as enjoyable as possible for them."

People liked living at the home, felt it was well-led and said they would recommend it to others. Comments included: "It's absolutely wonderful; yes, bring your Mum"; "It's better than Buckingham Palace"; "I think it's well-run; certainly nothing worries me here"; "[Staff] are well-organised; they're terrific"; and "You could not

find a better place".

People benefitted from staff who understood their roles and worked well as a team. A staff member told us, "There's good team work; we all muck in." Another staff member said "I think it's a good place to work, I'm very happy here." The provider sought feedback from staff about how the service could be improved and had consulted staff about the changes to their rota. One staff member said, "Headquarters staff came in to speak with [staff] about training and working hours. The new rota is on trial for a month, so we'll see how it goes."

Audits of key aspects of the service, including care planning, medicines, infection control, fire safety and the environment were conducted regularly to assess, monitor and improve the quality of service. In addition, managers and senior staff conducted spot checks of the cleanliness of the home and staff practices. The audits had been effective in identifying necessary improvements. For example, they had identified the need to refurbish the laundry room and this was planned. The system used to track staff training had highlighted that staff training was disorganised. The manager had put plans in place to improve this and, following the inspection, they sent us a spreadsheet showing that staff training had been brought up to date.

Quality assurance visits were conducted on a quarterly basis by a representative of the provider. The Operations Manager told us these were used to identify whether "the manager is doing what they say they're doing" and to seek the views of people through themed conversations. They included dip-sample reviews of care plans and had identified where information was lacking, such as the absence of care plan reviews by senior staff. They also included observations of meal times, which had led to the purchasing of additional serving dishes and the use of tea pots at breakfast. Conversations were also held with staff to check their knowledge and understanding of people's needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that care and treatment was only provided to people with their consent or in accordance with the Mental Capacity Act 2005. Regulation 11((1)(2) & (3).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people were protected from the risk of infection or that individual health and safety risks to people were managed effectively. Regulation 12(1) & 12(2)(a), (b) & (h).

The enforcement action we took:

We issued a warning notice erquiring the provider to take action.