Norse Care (Services) Limited

St Edmunds

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 12 October 2016 and we revisited on the morning of the 14 October 2106 to look at a number of further documents. The first inspection date was unannounced. The last inspection to this service was in May 2014 and the service was compliant under our methodology used at that time and has a history of compliance. Since the date of the last inspection there has been a change in manager and an increase in bed numbers from 35 to 40. There were 34 people using the service at the time of our inspection with a number of people booked to arrive.

On the day of our inspection there was a manager in post who has subsequently put in an application to the CQC to become the registered manager.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our inspection we found the staff working at the service were mostly regular members of staff and had managed well with all the recent changes to the service. A new manager had been recruited and a number of new staff had either started or were about to start work. Staffing numbers were being maintained but we felt numbers were on the low side particularly at night time when staffing levels was reduced to two staff. A number of people required two to one to assist with their manual handling needs. This meant there were no staff on the floor at some point during the night to assist others. We also felt there were insufficient time for activities, as reflected by people using the service and from the planner which showed activities planned on some days but not others. The activities which were provided were enjoyed. People expressed their appreciation for the staff and felt they worked hard to ensure their needs were met.

People received their medicines in a safe way by well-trained knowledgeable staff. Staff received the training they needed to be effective in their role and their performance was assessed and monitored.

People's needs were known by staff and potential risks associated with their care were mitigated as far as reasonably possible through robust risk assessments and through staff training. The environment was suitable to people's needs and was well maintained. Equipment was checked regularly to ensure it was safe to use.

Staff were regularly supervised to ensure that their work practices were in line with best practice and staff received adequate training for their role.

There was a robust complaints procedure and the service were responsive to any feedback given.

People's health needs were monitored by staff so appropriate steps could be taken or medical intervention

sought as required. Staff helped ensure people ate and drank enough for their needs to help maintain their weight and good health.

People were consulted about their care and consent was sought before any care was provided. The service worked in accordance with the law in terms of supporting people without capacity to make their own decisions.

People only moved to the service when an assessment of their needs confirmed the service was able to meet them. Needs were not always kept under review in a timely way. This might result in an increased risk of people not having their needs met or the service failing to recognise if staffing levels were adequate.

The service was well managed and there was a positive culture in the service. Staff development was supported and encouraged and good practice was the norm. People were receiving a good service and were actively asked for their suggestions to help the service shape and improve the service as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people's safety were mitigated as far as it was reasonably possible.

Recruitment procedures were robust to help ensure that only suitable staff were employed.

The numbers of staff on duty were provided according to the company rule set for determining staff numbers and based on a dependency assessment of individual needs. However we considered the staffing levels at certain times- ie night time to be on the low side.

People received their medicines in the way that was attended. Staff were suitably qualified to administer medicines safely.

Is the service effective?

Good

The service was effective.

Staff had the necessary skills and competencies to deliver the care that people needed.

There were systems in place to monitor what people were eating and drinking and to ensure they were having a balanced diet.

The service supported people in making appropriate decisions around their care and welfare and always ensured they had people's consent.

People's health care needs were documented and monitored.

Is the service caring?

Good

The service was caring.

Staff knew people's needs and provided care according to people's wishes.

The staff were kind, respectful and promoted people's independence and dignity.

People were consulted about their care needs and asked to comment on the service provided to them so adjustments could be made if required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were familiar with people's needs and responsive to any changes to them.

Records were comprehensive but all the care plans we reviewed were not fully up to date, and, or the information was difficult to find and we were not always able too see how they reflected the persons current needs. All care plans were updated annually.

Activities were planned throughout the week but insufficient to meet everyone's individual needs.

Is the service well-led?

Good

The service was well- led.

The last permanent manager was in post for ten years before their resignation in July 2016. A temporary manager was appointed pending the appointment of a permanent manager who commenced their duties in October 2016. The service has not been affected as there is a strong senior team in place.

There is a strong ethos and caring culture at this service.

Staff development is promoted and staff excellence celebrated. This has impacted on the morale of the service.

There are systems in place for the continued development of the service to ensure good outcomes for people

St Edmunds

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 the 12 October and again on the 14 October 2016 for a few hours. The inspection was unannounced.

The inspection team comprised of one inspector and an expert by experience. 'An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of supporting people living with dementia.

Before the inspection we reviewed any information we already held about the service. This included notifications which are important events the service is required to notify us of. We also looked at previous inspection reports and any feedback about the service including the provider information return, (PIR) which tells us how the service is managed in relation with the key lines of enquiry we inspect against.

During our visit we spoke with twelve people who used the service, two visitors and eight members of staff, which included senior staff, ancillary staff and care staff. We reviewed four care plans.

Good

Is the service safe?

Our findings

All the people we spoke with who lived in the service told us they felt safe in the service. One person said. "I think so (feel safe), they (staff) would help me if I needed it." "I can go down in the lift to the main dining room." Another person said "I feel safe, people are ok, and they are friendly." "They're just doing their jobs; they don't have time to chat, not really". And another said "Yes, I've got people around me now, I'd lived on my own and I got quite nervous at night. I have my door open here at night, I panic when the door closes due to the fire alarm going off."

All the staff we spoke with had a good understanding of what they should do if they suspected a person to be at risk of harm or actual abuse. Staff were able to identify poor practice and were confident in being able to raise concerns with team leaders, and, or the manager. They were aware of external agencies and their role and were able to explain when and why they would refer to another agency.

The provider told us prior to the inspection that a manager from the organisation attends the safeguarding partnership meetings and feeds back to the teams. Staff told us that they are able to access the Norfolk safeguarding team to log any concerns or ask for advice.

Staff received training on how to recognise and report any suspected abuse or where they identified a person at risk of actual harm. Staff had access to policies and procedures which they were required to follow to ensure people were fully safeguarded. This information was available in the service and could be accessed by relatives and people using the service if required.

People's individual risks had been assessed and actions put in place that protected them and promoted their independence. Steps had been taken to reduce risks such as lower beds to minimise risk from falls. Everyone had an individual pendant which they could use if they needed staff assistance. Staff carried phones so they could contact each other if necessary. For example a person fell in their room on the day of our inspection and staff were able to summons additional assistance quickly.

We spoke with people about their pendant alarm; some people said they never used them. However they were visible around some people's necks. The manager told us everyone was provided with a pendent alarm and some refused to use them. If people were not able or unwilling to use an alarm a risk assessment was in place for this to ensure staff were aware checked the person frequently. One person told us I don't like wearing the alarm pendant because I have (health condition), so I keep it on my walker, I keep it with me all the time." I used it this morning to say I wasn't going down to breakfast, they answer, speak to you over the speaker." I know they will answer you as soon as they can, five minutes, you have to be sensible about it." Other people confirmed five minutes or sooner was about the time it took staff to respond when the alarm was pressed.

The environment was suitable for people's needs. The main entrance was secured by a locked entry system with a code on display for exiting the building with the managers and administration offices adjacent. The reception area, communal rooms, corridors and people's rooms all benefited from both good natural light

and adequate artificial lighting including sunlight tubes. There were storage rooms for hoists and equipment and people's wheelchairs were parked in recessed areas along corridors and did not appear to provide a hazard to people passing by.

Specific equipment checks were carried out routinely to ensure equipment was safe to use and we looked at a sample of these records. People had their own manual handling slings and staff told us there was enough equipment to help people with their manual handling needs. People had manual handling plans in place and were supported by staff who were trained in manual handling techniques.

Risks to people's safety were monitored and we viewed incident/accident records which were collated and showed actions being taken following an incident. The service notified the CQC and the Local Authority as required. Falls were also monitored and the service had good links with other care professionals to ensure any risk to a person's safety was monitored and referrals to the right service could be made as required.

There was the number of staff on duty that the service said they needed. The manager felt staffing levels were sufficient to support people with their needs.

We asked people using the service about staffing levels. One person told us "Not always (enough staff), there's a staff shortage here at the moment, they're using some agency staff, some are very good". "Things are taking a little longer; I try to be as independent as possible." Another said, "I know they have been a bit short of staff, they've got several new ones, at least three of them. Relatives commented that they felt there were enough staff.

We spoke with staff one told us, "They do try hard here to keep the right staff, most of the staff are experienced and some have been here many years."

During our inspection we observed staff who were familiar with people's needs providing care and support in a timely, responsive way. There were a number of agency staff on duty but they were familiar with people's needs and able to respond effectively to people's care needs. There was also a new member of staff on duty who was shadowed by a more experienced member of staff and not being left to work unsupervised.

Since the last inspection there had been a number of changes to the service and some staff had recently left. Their posts had been recruited to and new staff had either just started or were about to once all the appropriate checks were in place. The manager told us they had a pool of bank staff and relief staff they could use to cover shifts and regular agency to cover any vacant shifts as a result of sickness or holidays. This meant the shifts ran as they should with the number of staff they said they needed.

We checked the staffing rotas which showed a minimum number of five staff on duty as well as the team leader together with management and administrative staff. One member of care staff commenced their morning shift at 6.00 am and finished at 11.00 a.m. This supported the night team and enabled the service to be responsive by deploying staff in a way that best meets the needs of people using the service.

The manager told us the number of staff on duty were provided according to the company rule set for determining staff numbers. The service used a dependency tool to assess if people were low, medium or high need and this would be used to calculate the staffing hours needed. The tool took into account the specific needs of individuals but did not take into account the physical layout of the building which was very spread out, over two floors and with a number of separate lounges and dining areas. The provider has confirmed that if there was a particular issue about the building layout then additional hours would be

allocated.

Staff were employed specifically to plan activities for people which were supported by care staff to help people access a range of activities taking place in the service. However based on our observations and listening to people that use the service there was insufficient activity for people and activities only took place in a morning or afternoon and not every day.

There were two staff at night which through our experience is on the low side as night staff were expected to support people to bed and assist them up in the morning, complete regular checks, complete cleaning and domestic chores and administer medication. In terms of people's dependency five people needed the support of two staff to assist them with their manual handling needs which meant if night staff were assisting them no one was attending to everyone else using the service. The manager told us night audits were completed to assess how people's needs were being met at night. However these audits focused on records and not people's experiences. The audit tool to help determine staffing levels did not take into account factors which affect people's overall experience of care and might impact on it. The manager assured us that if there was any evidence people's needs were not being met staffing levels would increase accordingly.

There were systems in place to ensure people received their medicines in the way that was intended. One person told us. "I do my own medication; the girls come round and distribute them."." Another said, "They give it to me in the morning and evening, I'm happy they're giving me everything I should have, usually they stay (while they take their medication.)"

We observed people being administered their medicines. Staff took their time to explain to people what medicines they were being administered and if they were all required such as pain relieving medicines. People gave their consent and staff ensured medicines were taken safely before signing to say, it had been administered. Medicines were kept safe and locked away at all times.

Staff administering the medicines were very knowledgeable about the medicine's they were administering and how to administer medicines in accordance with the service policies and procedures. People's records were clearly laid out to show what people were prescribed, at what time and any specific instruction staff needed to be aware of such as potential side effects or whether the medicines had to be administered at a specific time. There were protocols in place for medicines administered as required such as pain relief and there was a specific tool used to help staff assess people's pain level.

Medicines were stored safely at the correct temperatures. There were weekly and monthly medication audits. We also saw a recent audit completed by a compliance manager employed by the organisation. This highlighted a number of areas which required improvement. An action plan was in place to address concerns with immediate effect. Staff told us these had been rectified although this was not indicated on the action plan.

There were systems in place to support people to continue to take their own medicines if they wished and it was safe for them to do so. This meant the service promoted people's independence whenever possible and there were a number of people taking their own medicines

Staff told us that before administering medicines they observed a staff member on three separate occasions and then were observed three times administering medicines. Only when they were considered competent would they be signed off to administer medicines on their own. We saw sight of the training and assessment of competencies which had been undertaken.

In people's daily notes we identified concerns about people not always being discharged from hospital with a discharge record or with the right medicine or the right dose. This was discussed with the manager to help ensure that mistakes in medicine are quickly addressed to ensure people could be sufficiently protected. We noted safeguarding concerns had not been raised by the service when other services had made an error but had when the service had made an error in medicines.

Recruitment processes were sufficiently robust. There were processes in place to ensure staff were recruited on the basis of merit having demonstrated they had the right attitude and character. Interview notes were indicative of this. Staff records showed the necessary recruitment checks had been carried out. Staff were only employed when there were satisfactory references, a criminal records check and employment history check. Medical information, proof of address, right to work in the UK and proof of identification were also required.

Agency staff were used as this service and they were subject to the same stringent recruitment checks of which the service had copies of. They also had an induction before starting work to ensure they were familiar with the service and the needs of people using the service. Whilst employed they were shadowed by more experienced staff,

Good

Is the service effective?

Our findings

Staff were knowledgeable and able to meet their care needs. One person told us, "Yes they (staff) are quite competent, they do know what they're doing." We observed staff and saw that they were competent. For example, we observed three staff members assisting a person to transfer into their bed using a hoist. The staff were overheard to be attentive and reassuring whilst encouraging the person to assist during the transfer process. We observed staff at lunch time and they were able to tell us about people's specific dietary requirements and any risks associated with them such as the risk of chocking.

We spoke with an agency member of staff who told us this was their favourite home to work in because they found all the staff nice and helpful and standards of care high. They described people receiving cohesive care.

Staff were supported in their role to help them provide consistently high and effective care. New staff were subject to a six months probationary period and during this introduction in to the role had to undertake a variety of training courses, shadow shifts and direct observations of practice. New staff were enrolled on the care certificate which is an induction workbook which is nationally recognised and gives staff the knowledge and competencies required to work in the care sector.

Staff spoken with confirmed there were regular observations of practice and one staff when asked what training they had done recently said, "First aid, moving and handling, hygiene, safeguarding, Mental Capacity Act and Deprivation of Liberties safeguards." Staff were also provided training around people's more specialist needs such as diabetes and dementia.

Some of the training was provided through an individual training system staff accessed via the computer. The organisation had its own staff responsible for training. We saw the training matrix and evidence of staff supervision but this was not up to date for all staff. This was being addressed. With immediate effect. Staff champions were either in place or being developed and they had enhanced knowledge of a particular area of health care. Examples including dignity champions and dementia champions. Staff took a lead role in this area to try and support staff and promote best practice.

One staff member confirmed "We have staff meetings every two months, usually in work time, there's a good positive atmosphere amongst the staff."

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

People we spoke with told us staff sought their agreement before carrying out any personal care and staff respected their wishes. One staff member said, "Staff let them make their own choices but we advise them of

the likely risks." One staff member told us, "People have a choice with everything; we try and offer a choice, even if it's a limited one". "I think it's important to always explain things even if they don't appear to understand."

This is what we observed throughout our inspection with staff offering choice and where a person seemed not to understand staff tried to explain it in a different way including using visual aids to support decision making.

We observed staff providing support to people and did so with time and care. They gave people time to respond and gave them appropriate choices and did not assume what people wanted.

Staff had received training on the Mental Capacity Act 2005 and supported people in appropriate ways with the least restrictive option in place. There were polices in place to guide staffs decisions.

We looked at a number of care plans and saw people had consented to care and there was a document stating if people were deemed to have capacity. In each record it said people had but these had not been kept under regular review. .

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Some people had a deprivation of liberty in place which meant it would be unsafe for them to leave and as such they were supported by staff to ensure they remained in a place of safety. Other people had the doors codes and were able to move about freely. The manager told us most people could give consent but some more complex decisions were sometimes taken in people's best interest. They said they followed the established principles of this to ensure a person's interest was protected. One example given was to protect a person from financial abuse. The manager had taken steps to determine who had legal responsibility to make decisions for people where they lacked capacity to make them and this was recorded.

People's health care needs were responded to by staff. One person told us their health care needs were met. They said, "I regularly see the doctor/nurse and the optician." Another person said, "The district nurse and nurse practitioner visit me, my (relative) will make me an appointment with the doctor, they reported (my condition) yesterday." "Doctors are a scarcity, if you can't see the doctor you can always see the nurse practitioner, she comes here twice a week".

The service had good communication with the local GP practice and a named GP who visited each week. In addition a nurse practitioner was assigned to the service and provided weekly support and held weekly meetings to ensure anyone needing the support of a GP was seen. This meant people needs were responded to in a timely manner. Staff at the service received training in how to avoid hospital admissions. This helped staff to monitor people's health and well- being and identify early signs and symptoms of illness. For example dip testing of urine was regularly done if people were presenting with a number of symptoms. This ensured people could get early treatment.

People's health care records demonstrated that staff were monitoring people's needs and where appropriate people had district nurse input. Any equipment they might need to promote their health, particularly in terms of their skin integrity and management of short term illnesses and long term conditions.
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The care plans addressed people's needs and including important information such as people's oral hygiene and if they needed glasses and hearing aids to ensure their sensory loss was appropriately readdressed. People's wishes about resuscitation in the event of their heart stopping were known by staff and the appropriate paperwork was in place. The information was easily accessible.

People received a balanced diet and people were complimentary about the food. We asked one person about their meal and they said, "I'll be honest with you that was lovely." Another person told us "It's good food, it's always hot. We always have a Sunday roast with puddings and all the trimmings". "There's a book showing you all the meal options. Sometimes we have a menu on the table with pictures, they ask you (meal choice) when you sit at the table, there's usually two or three different puddings, treacle, bread and butter, spotted dick". "You get a cup of tea in the morning; we should get a cup of tea about now (10.45), water, lemonade or blackcurrant with lunch and an afternoon cup of tea". "Mostly I go down for tea about 4.30, there are always sandwiches, a selection of four or five different ones, specials hot pizza, sausage rolls, scrambled egg." Another said "The food here is very uninteresting; I don't have any lunch at all I have lost quite a bit of weight since I came here. Their records confirmed this but they were not underweight and staff were monitoring them.

The chef was knowledge about people individual and specific dietary requirements. We also found care staff were aware of people's dietary needs. The chef told us they had recently attended an allergens course and told us of how they were now far more aware of the dangers to those people at risk and the importance of food hygiene procedures. They further demonstrated to us their clear understanding of fortified meals and drinks and provided examples of how people's needs were supported. They told us they had no involvement with the recording of people's fluid intakes and that this was the responsibility of care staff. Some staff had completed specific courses on the screening tool, malnutrition; universal screening tool, (MUST.) Care staff were also knowledgeable and we saw care plans recorded the level of support people needed and included information about any specific dietary needs.

We observed staff promoted choice and offering people support as they required it. At lunch time we observed both floors and saw that staff worked efficiently to ensure people got their meals in a timely way. People's independent was promoted. Staff placed vegetable dishes on the table for people to serve themselves and there were also condiments, salt, pepper, jugs of gravy and cranberry sauce for the turkey on the table. There was not a lot of food waste but we did note that upstairs more than half of the people chose to eat in their room and we saw a number of people had barely touched their meal and were not given encouragement by care staff who were focused on those who needed more assistance in the dining room. In the main dining rooms staff served meals and offered alternatives choices where the main meal was not wanted.

We noted downstairs the environment was clean and bright, and people seemed reasonably relaxed and a calm environment persisted throughout with quiet conversation punctuated by two (agency) staff members who conversed in a friendly upbeat manner, made eye contact and engaged in positive and appropriate conversation. Staff told us when asked that all those present in the dining room were able to eat independently. Upstairs staff were equally upbeat but staff did not sit and chat or eat with people which might have enhanced their experiences. The atmosphere was subdued.

People were able to access drinks through the day and there was a separate kitchenette upstairs. The tea trolley service arrived at 11.40 when hot drinks and biscuits were offered and then lunch again at 12.30. Individual water jugs were placed in people's rooms.

Good

Is the service caring?

Our findings

The feedback from people about the staff that supported them was wholly positive. One person said, "Yes the staff are all nice and friendly, good to chat too." Another said "All of them are very nice and friendly, all approachable and they talk to you about your family". "Even the window cleaners are friendly." Another said. "Yes they're well organised, they are patient, they have to be and they do listen. I'm always helped into and out of bed."

We observed that people generally appeared to be well groomed and appropriately dressed with suitable footwear. One person had long finger nails but told us this was their preference and we observed that these were manicured and clean. People confirmed staff kept their nails clean where they were not able to.

The environment was fit for purpose and helped facilitate people's independence. For example people had their name and some personable to them on the door to help them identify their room. The service was spacious, clutter free and people had individual pendants which meant they could walk around freely and still be able to summons help should they need it. The service was arranged in such a way that it helped people in their friendships and socialisation with others such as chairs were arranged in small groups and facing the windows so people could see what was going on outside. A shop and bar were available to people. We did note that signage in the service did not always enhance people's independence in terms of navigating around the service and we observed several people losing their way.

Appropriate signage could enhance people's experience and help facilitate their independence.

Staff were mindful of people's needs and there were systems in place to ensure staff worked in accordance with the ethos of the service and provided good care. Training, and dignity champions leads were two examples of this. Staff have annual safeguarding and promoting dignity training. We asked staff about how they respected people's dignity to which one replied. "I always try to imagine if it was me and how I would feel, make sure that you are covering them up and always talking to them and answering their questions". "I lock the door in the bathrooms when bathing a person as residents can just wander in" we observed staff when going round knocking on people's doors and waiting for a response before pooping their heads in to say hello and asking if they could assist people.

Staff interaction was positive. We heard staff encouraging people and validating how they were feeling by repeating things back to them to ensure they had understood. Staff were attentive and ensured people were well dressed, groomed and had everything they needed. For example when assisting people with their tables the staff gave them simple instruction, encouragement and praise. We noted through our observations that there was a lot of positive energy in the service with staff seemingly very upbeat and motivated in their work.

People were judged to have capacity and able to make their own decisions but a number of people might need help with this. Staff said no one had an advocate but people did have family members or they could refer to Age UK or other voluntary/statutory organisations for advice. They also had a number of visitors who

use to have relatives at the service.

People were consulted about their care. One person told us "We have a meeting once a month with the managers." The service had an open door policy and regular resident, relative meetings which were minuted and showed what actions had been taken as a result of feedback received from people. This showed the service was responsive.

Requires Improvement

Is the service responsive?

Our findings

Overall we found that staffing levels within the service did not enable staff to adequately respond to people's individual needs in regards to their interests and hobbies. This did not help to promote their emotional and social well- being. It was clear to us that the work undertaken by the activities co-ordinator was highly valued by people using the service but the hours provided were not sufficient to meet individual need.

We spoke with people using the service who told us that staff without exception were kind and able to meet their needs. We asked people if they were supported to maintain their hobbies and interests. Some people told us they were happy to spend time in their rooms and had everything they needed. We observed others socialising with other people in the service with whom they clearly had a bond with .There were also a number of visitors in the service and they told us they were always made welcome.

We did however observe a number of people who were isolated and with more encouragement and more on offer they might be encouraged to join in. The activities coordinator was new to post and was only given 16 hours a week to plan, provide and facilitate activities. The notice board detailed planned activities but there was not something every day. We spoke with the activities co-ordinator who told us they were organising three specific activities each week including sports games (using a television), the showing of old films and the opening of a shop / pub where they would serve non-alcoholic alternatives including smoothies and milk shakes. They were also planning themed events around Halloween, making arrangements for a singer to attend and for the annual Christmas card competition held throughout the Norse homes. It was clear when we spoke with people that the activities person was highly regarded in the service but simply did not have sufficient time.

We spoke with staff who told us no one currently helped in the garden. We spoke with one person who told us they were a gardener in their earlier year and there was no evidence staff had tried to engage them in maintaining the garden. Staff told us volunteers had helped to landscape the garden and create a sensory garden for people to enjoy. We spoke with another person who when we asked if they joined in activities they replied, "Well there's nothing much to do. I did go down to watch a film the other day, 'grease,' but the other people just fell asleep. "We asked them what they did to occupy themselves and they said, "Nothing, watch my television mostly." Through our observations we saw some people had little in the way to engage them and saw some people slept throughout the morning and were not provided encouragement to participate in anything.

One person told us "I stay in my room an awful lot - actually nobody does anything here to pass the time, we have our breakfast and lunch and the rest of the time we're left to our own devices, sitting here and doing nothing – just looking at trees all day is not my idea of life". "I feel quite down in the dumps, depressed about it". Another said, "They normally have a monthly programme, we've got out of sync at the moment, they come and tell you, ask if you're coming down to bingo". "We have board games once a month, entertainment for practically all afternoon; we have done a bit of painting, usually nearer Christmas, because of the Christmas cards". "You can go in the garden, the men can have a smoke in the corner, I sit out

there but there's not a lot of people take advantage, one or two in wheelchairs, you see them outside". "I've often wondered why more people don't go outside. "Another said, "I listen to the radio, one of the team leaders brought in the radio for me." One person told us, "You can go about here wherever you want to; you have to tell them when you're going out". "They do encourage you, you can get stuck in a rut, and they do bring people down who are a bit hesitant."

Staff confirmed the limited activity for people one said, "for the last couple of months it's been quite boring, he, (the activities coordinator) has a lot of plans, and I think we'll see an improvement with that." However it was also documented that they were leaving and would need to be replaced. Another said, "We need more staff to do some sort of activities with the residents you do need quality time with the residents."

People's care plans were developed and reviewed by staff and included a section which said people had been involved and consented to their care. Care plans were held electronically but there was also a separate care plan in people's rooms so people could see what was recorded. It also meant visitors could see what care was being provided. We asked a number of people if they were involved in their plan of care, several people said no but one person said "I haven't looked at it; they discussed it when we first came." We saw they had signed it. Another person said The lady who's in charge came one evening and asked all sorts of questions about my background.

Through our conversations and observations of staff it was evident that they knew people well and could respond appropriately to their needs. Staff responded to people in a courteous, friendly way, showing genuine warmth and affection for the person and valuing them.

There was good communication with staff having a handover at the change of each shift to communicate anything important and there was a system to prioritise urgent need. New staff spoken with also told us they had been given sufficient time to read people's care plans which they had found very helpful in establishing people's main needs.

We reviewed people's care plans and found they were written in such a way that they gave a good insight into what the person's needs and routines were and how the person wished to be cared for. It included information which was important for staff to know such as the person's history and life experiences, how they felt about different things such as how they relaxed and what worried them. The care plans included actions for staff to take to ensure the person's needs were being met.

Although records were in place and showed how staff were providing care to people we found this somewhat confusing due to the number of different records in place. For example, there were electronic care plans which were updated, printed off and a paper copy available in people's rooms. This included an index as where to find all the relevant documentation. Daily notes were written by care staff and the team leaders updated the main care plans. We found it was not possible to establish how the person's needs were being met without reading all the available documentation. There were also separate monitoring records for various things such as food and fluid recording for some, a falls register which again was kept separately.

When reviewing people's needs we were unable to establish how a number of risks associate with people's care were being effectively monitored and the necessary actions taken. For example a number of people were prone to urinary tract infections and prone to constipation. We saw from their records that they had suffered from both. However there was no effective monitoring of this to ensure they were drinking sufficiently and their diet was adequate for their needs. We saw from their records that they had a number of infections which required antibiotics but were unable to establish from their records how much they were drinking daily. People prone to constipation had regular entries about their bowel movements but because

the information was recorded in different places was difficult to track and could be easily missed.

We found the care plans were reviewed at least annually or as needs changed as was the organisations expectation. Care plans were devised following an assessment of need before admission and further on-going assessment when people moved in. For example people had their weights taken and then staff monitored what people ate and drank in the first three days to form a judgement about risk. The most recent pre-admission assessment seen did not give a lot of information but was laid out in a tick box formation and did not show who had been involved in the initial assessment. However the manager said there would be supplementary information from risk assessment documentation and assessments from the local Authority. We saw that care plans had been implemented quickly and had been reviewed but the review process was not always identifying changes in people's needs. For example, we saw one person who had been losing weight, their record included a gap of several months where they had not been weighted and an entry when the person had lost weight but no action identified. Further weight loss showed actions taken to prevent any further weight loss. This included being weighed weekly from 22/09/2016. The person had not been weighed at the time of our inspection or their care plan updated to reflect a change in their needs. They were also being given build up drinks and this was not reflected in their care plan. We reviewed another person who had recently had a change in need and reduction of their independence; this was not reflected in their care plan. They had been recently discharged from hospital and had not been weighted for ten days after discharge. The manager told us they would not routinely weight a person on return from hospital unless there had been concerns about their eating and drinking. Another person's care plan referred to them eating a normal diet. Their record indicated that their diabetic condition had been unstable and there was not an effective plan in terms of their dietary need. Records did not always reflect a change in people's needs but we were confident that staff were responsive to people's needs. However inaccurate records could increase risks of people receiving the wrong care.

There was a robust complaints procedure in place and the service took into account how people experienced the service. People and relatives did not raise any concerns with us, and felt if they did they could speak with staff. One person told us, "There's nothing to report really, if I did have anything I would go down and see (assistant manager.)" Staff were equally clear about how they should respond to people's concerns. One staff said, "You would do your best to try and resolve it, to them it's important, even something small."

The complaints procedure was accessible and there was also a suggestion box and a sheet in which people and staff could comment on the manager. This would then be reviewed by their manager. We looked at the last three complaints about the service and these had been recorded and addressed within the agreed timescales.

We also saw a number of compliments about the service which reflected the high standards of care being provided most of the time at the service.

Good

Is the service well-led?

Our findings

eople we spoke with were aware of recent changes in the service. One said, "They (staff) seem to get on well together; they do tell me what's going on." Another person said to us, "The new manager took over this morning; the previous one was taken ill two months ago and isn't coming back."

There were systems in place to assess what people felt about the service they received and if they thought anything could be improved upon. In 2015 surveys were sent to everyone using the service. There were 24 people who responded and the service scored highly in all areas including how safe people felt and how satisfied they were with all aspects of care. The service had sent out surveys recently for this year and were still waiting for more to be returned before they collated the results. Surveys were not sent out to relatives or health care professionals but they had an opportunity to have their say as there was a suggestion box and open door policy. Following the issue of surveys the results were collated and then the service published the results on the notice board, saying you said, we did, showing actions taken to improve the service.

Relative/resident meetings and individual care reviews were also held and gave people formal opportunities to discuss the care and the service as a whole. We saw minutes of meetings held and how people were consulted about a wide range of subjects and how the amenity funds should be spent to benefit people using the service. A number of people were living with dementia. Staff told us the survey had been adapted so they were fit for purpose. In addition they told us that staff supervisions were all but two around the interactions and care they were delivering which was assessed through direct observations of their practice. This helped senior staff make a judgement about staff practice and people's care experiences. There were other audits carried out by senior management of different aspects of the service delivery such as the night routines and the dining room experience for people.

Since the last inspection by the CQC in 2014, the registered manager has left and there have been two further appointments of manager, the latest being in the last few weeks. The manager was not on site when we arrived and were told they were helping overseeing another service as well as this one which did not have a registered manager. They were familiar with the systems but had not yet had sufficient opportunity to get to know people using the service. They told us they were well supported by an established team of staff including an assistant manager and seven team leaders. They told us the arrangement of covering two services was coming to an end. They also told us all their managers worked every other weekend which helped them keep up to date with people's needs as they often would be delivering care. They told us they had been supported by the previous manager and had been given a full induction and were sufficiently experienced and qualified. Since our inspection the new manager has put in an application to be the registered manager.

There were enough staff with the right skills and expertise and there were systems in place to support staff with obtaining additional qualifications and taking lead roles in certain areas of health and social care such as dementia champions. Staff in these roles would have specific responsibilities and provide support to other staff. They might under-going specific training for their role as was being provided to dementia champions. We found the deputy and team leaders spoken with were very knowledgeable and competent.

The service developed its staff and provided opportunities to support staff with additional qualifications. We found staff already held or had been enrolled for additional qualifications.

The manager told us there was really good support from the organisation which was small and personable. They said there was good support from their line manager who frequently visited the service and carried out their own audits. We saw a sample of these. There was good support from one service to another with managers being familiar with other services other than their own so able to help as required. In addition they had a pool of staff they could use if required to reduce their reliance on outside agency staff. They told us managers frequently meet and provided mutual support to each other and shared good practice. Mock inspections were carried out by managers to other homes and these were unannounced. This helped managers ensure they were running compliant services.

Equally staff told us they felt well supported and it was a good company to work for. One staff member said, "I feel the team, I work with are brilliant, whenever I've needed help they've provided it."

In addition to this staff told us how they had been individually nominated in recognition of the work they do every day. The organisation held annual ceremonies where they celebrated staffs success and used this as an opportunity to reflect on the good work they do in supporting people and their families. We saw nomination forms completed by people who used the service or their relative where they had nominated staff.

The provider told us they were working towards accreditation as a commitment to quality, customer care, and toward improving efficiency through effective management systems which met agreed external standards. The service already had staff trained in auditing and measuring the standards of dementia care, it was providing against an agreed framework.

The risks to people's well-being and safety were monitored and steps taken to reduce risks to people as far as possible. For example through staff training, audits of care and spreadsheets capturing specific data such as falls, how this was managed and what steps had been taken to prevent further falls where possible. By presenting information in a spread sheet there was the opportunity to analysis the data and identify possible themes and trends so adjustments could be made where possible. For example, if most falls were occurring in a specific time frame this might be indicative of insufficient staffing.

Individual records included a risk section and we saw very detailed manual handling plans and risks associated with people's individual conditions. We did have concerns about a number of areas of health care for individuals which had not been reflected in people's care plans as reviews of people's needs were not always occurring regularly. The organisation had people employed specifically to monitor the service and carry out spot checks on a number of different areas such as activities and records. This would look at the paperwork to ensure activities were taking place and reviewed to show their appropriateness and whether people enjoyed them.

We found this service providing very good standards of care but felt better community engagement and more individualised activities for people would accelerate this service to a possible outstanding rating. We noted a number of people were able to go out independently and we observed a person accessing the grounds. There were very few restrictions on people and the service was located in a good spot close to amenities. However the service only had one volunteer and limited engagement with community groups which would enhance people's lived experience.-Staff helped fund raise to increase the opportunity for people to go out, for example the residents amenity fund paid for a pantomime at Christmas and also covered alcoholic drinks at Christmas time.

We asked both staff and people using the service what if anything could be better to which they replied more activities and more training due to changes in people's dependency levels. When we asked about the strengths we were told the friendliness of the staff, the team work and the environment.