N. Notaro Homes Limited

Clarence Park

Inspection report

7-9 Clarence Road North
Weston Super Mare
Somerset
BS23 4AT

Tel: 01934629374
Website: www.notarohomes.co.uk

Date of inspection visit:
09 November 2016

Date of publication:
06 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 November 2016 and was unannounced. The service was last inspected on 13 January 2014 and no concerns were identified.

Clarence Park provides accommodation for up to 43 older people who need nursing and/or personal care. At the time of the inspection there were 36 people living at the home. Many of the people had mobility needs and needed staff assistance to move around the home in wheelchairs, or they used mobility aids to assist them with walking. People also had a range of other needs, including; sensory disabilities, early stage dementia, and other nursing or support needs.

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

The registered manager had worked at the home, in the capacity of deputy manager, but had recently been appointed as the permanent replacement for the previous manager of the service. The new manager was highly regarded by the people who lived in the home and by the staff. It was evident from our discussions that they had started to make improvements to the way the service was run. However, we found there were other areas that required improvement.

People told us they felt safe, but we found people's needs were not always consistently met in a timely manner when they pressed their call bells for assistance. This meant there could be a risk of delay in responding to an accident or other health incident. Either there were not enough staff on duty or they were not deployed in an effective way. Staffing was particularly stretched during the busy morning period.

We found inconsistencies in people's care records and in the frequency of care plan reviews. We did not see evidence of inappropriate care; but the failure to keep up to date records meant there was a risk people may not have received care in line with their current needs.

The service adopted a person centred approach to care planning but more could be done to ensure a consistently good person centred approach by all of the staff. Some of the staff were better at engaging with people than others.

The provider had a quality assurance system which had previously identified some of the above issues; but it had not operated effectively in terms of resolving and sustaining the identified areas for improvement.

People's nutritional needs were met and, once everyone was seated, people's lunchtime experience was good. However, there were delays in getting everyone seated before staff started serving their meals. We have made a recommendation about improving this aspect of people's lunchtime experience.

People told us staff were good at providing the care and support they needed. One person said "They are very good with me. I need two staff and a stand aid to help me get into my wheelchair. They seem to have everything I need here. The chef is wonderful, I'm on a diet but I'm never hungry". Another person said "Everyone's lovely and they all muck in. I'd recommend this home to anybody. The manager is brilliant, she loves us all".

Overall, staff displayed a friendly, kind and caring approach toward the people in the home. Apart from the delays referred to above, staff cared for people in a supportive and considerate way; such as when they were supporting people to move around the home and when assisting people at mealtime.

People were protected from abuse and risks were identified and managed in a way that helped people to remain safe. The premises were adapted for wheelchair use and there was a wheelchair accessible lift to the first floor. People received their medicines safely from registered nurses and were protected from the risk of infection through appropriate staff training, policies and procedures.
Support and advice was obtained from external health and social care professionals when needed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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 consistently safe.

People's needs were not always met in a timely manner which meant there was a risk of delay in responding to an accident or health incident.

Generally risks were identified and managed in a way that helped people to remain safe from avoidable harm.

People received their medicines safely from registered nurses and were protected from the risk of infection.

Is the service effective?

Good

The service was effective.

People received care and support from staff who were trained to meet their needs.

People were supported to maintain good health and to access external professionals when more specialist advice or support was needed.

People's nutritional needs were met, including any special dietary needs.

The service acted in line with current legislation and guidance when people lacked the mental capacity to consent to aspects of their care.

Is the service caring?

Good

The service was caring.

People were supported by kind, friendly and considerate staff.

People were treated with dignity and respect and were encouraged to be as independent as they were able to be.

People were supported to maintain continuing relationships with their family and friends.

Is the service responsive?

Requires Improvement

The service was not responsive enough to people's needs.

People's care records were not always up to date or complete. People may not have received the care that was most appropriate to their current needs.

People had some opportunities to engage in social and recreational activities but this could be improved.

People had opportunities to express their views and the service responded to feedback or complaints. However, this appeared more reactive than proactive.

Is the service well-led?

Requires Improvement

Aspects of the service were not well led.

The provider's quality assurance system had not operated effectively, or in a timely manner, to resolve previously identified areas for improvement.

People who used the service and staff told us the registered manager and the deputy manager, were very open, approachable and supportive.

People told us the regular care staff were caring and ensured their needs and preferences were met. Overall, staff were motivated and keen to promote people's health and well-being.

Clarence Park

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 9 November 2016 and was unannounced. It was carried out by one inspector.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about), other enquiries received from or about the service and the Provider's Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The service was last inspected on 13 January 2014. At that time, the service was meeting essential standards of quality and safety and no concerns were identified.

Some of the people who lived in the home were unable to fully express themselves verbally, due to their health conditions. We therefore spent time observing the care and support practices in the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we also spoke with five people who lived in the home and eight members of staff. Staff included the registered manager, a registered nurse, care assistants, an activities co-ordinator, a domestic, the chef and the home's administrator. We also spoke with the provider's Quality Performance Manager who visited the home at the end of the day.

During the inspection, we looked at records which related to people's individual care and to the running of the home. These included three care plans, medication records and some of the provider's quality assurance records, including staff training, complaints and incident records.

Requires Improvement

Is the service safe?

Our findings

Although people told us they felt safe, people's needs were not consistently met in a timely manner. There were delays in staff responding to people's call bells which were ringing almost continuously for long periods of time prior to lunchtime. The noise was loud and intrusive. Staff had no way of knowing whether a call was serious or urgent until they responded and checked whether people were safe. For example, a person may have fallen or be experiencing a serious health problem, such as a heart attack or stroke. The delays indicated either there were not enough staff on the morning shift or they were not deployed effectively.

The registered manager told us the staffing levels were seven care staff and two nurses on the morning shifts and six care staff and one nurse in the afternoons. At night time, there was one nurse and three care staff. Staff confirmed this was the usual staffing level and said management always tried to cover any staff shortages by offering additional shifts or using agency staff. The registered manager was a qualified nurse and helped out whenever needed, for example, she helped with the medicines round on the day of our inspection. The activities coordinator also assisted care staff at busy times such as mealtimes. The service also employed a chef and other catering and domestic staff.

We discussed our concerns about the call bell responses with the registered manager and the provider's quality performance manager. They told us various trials had taken place to try to improve the call bell arrangements. For example, staff had been assigned to specific areas of the home to avoid having to walk long distances to answer bells. Individual pagers had been purchased to notify staff when people pressed their call bells. The pagers made a less intrusive bleep noise, and could be set to vibrate only. The registered manager said the pagers were expensive and several had been lost or damaged. They currently only used the pagers at night time to prevent people from being disturbed when they were sleeping.

We asked people how quickly staff responded when they called for assistance. Most of the people said staff usually responded fairly quickly, within a few minutes, but one person said "It can be 15 to 20 minutes and sometimes it could be more. They haven't got enough staff. By the time they get here it's too late and I've had an accident. They say it's alright and clean me, but it's not nice for me".

We obtained a print out of the call log for the day of the inspection from the registered manager. This recorded each time a call bell was activated and when staff attended and reset the system. Following the inspection we analysed the response times, which we had to calculate manually from the call log data. The staff response times after lunch were reasonably quick with an average response time of 3 minutes, and the longest response time was 9 minutes. However, during the busy morning period before lunch, the response times were much slower. They ranged from 3 minutes, to 70 minutes on one occasion, and a number of response times were in excess of 20 minutes. Based on the call log, the average response time in the morning was 19 minutes, although this reduced to 12.5 minutes if the 70 minute record was not included (see below).

Call activity monitors were located around the home to enable staff to see the location of each call and how

long since the call bell had been activated. The longest unanswered call always appeared at the top of the screen. After 6.5 minutes a P symbol appeared next to any unanswered call to notify staff that this was now a priority. The log showed almost all of the calls in the afternoon were responded to within the 6.5 minute threshold. However, with just one exception, all of the calls in the morning exceeded the 6.5 minute priority threshold. This showed that people's needs were not consistently met in a timely manner.
During the inspection, we also observed care staff were very busy supporting the large number of people in the home who had mobility and other sensory needs. This was particularly evident at lunchtime when staffing was clearly stretched as it took an hour for all of the people using the dining room to be seated at the tables and then served.

Our observations showed the numbers and/or deployment of staff needed to be improved. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

Following the inspection we asked the provider to investigate the 70 minute response time. We were told the daily monitoring charts for the person in question showed staff had attended to them on two occasions during this period, but they had not realised the alarm had been activated. When staff attended on a third occasion, they deactivated the alarm but thought they had accidentally activated the alarm themselves while carrying out personal care. The registered manager has taken written statements from staff that verify the person was not left unattended for this extended period of time.

Since the inspection, the registered manager has informed us that two members of care staff are now specifically designated with the responsibility for answering call bells during busy periods; and nursing staff are responsible for monitoring the call bell responses. In addition, the pager system has been re-introduced during the day time to reduce the noisy and intrusive nature of the call bell system.

People who lived in the home told us they had never witnessed any inappropriate staff behaviours and said they felt safe at the home. One person who lived in the home said "The carers and nurses are all very nice. I've never had any trouble with anybody". Another person said "They are very good here. They all do their best I must say".

The service protected people from the risk of abuse through appropriate policies, procedures and staff training. This included effective recruitment and selection processes for new staff, such as, seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks a person's criminal history and their suitability to work with vulnerable people. Staff said they had no concerns about any of their colleagues' practices but they would not hesitate to report anything if they had any worries.

Care plans included risk assessments outlining measures to ensure people received care safely. The assessments identified people's individual equipment and staffing support needs. They covered areas including: mobility and pressure sore risk, falls, use of bedrails, malnutrition screening, swallowing and choking, personal hygiene, and medication. There was a range of equipment available to meet people's individual needs. This included hoists, assisted bathing equipment, wheelchairs, pressure relieving mattresses and mobility aids for people at risk of falling.

Staff knew about people's risks and how to reduce the potential risk. For example, several people were assessed as at risk of falling. Information was recorded in their care plan on how to reduce the risk, including ensuring they always used their walking aids and staff remained observant. During the inspection we observed staff reminding people to use their walking frames, not to hurry, and supporting people to sit

down or stand up safely. Similarly, several people were at risk of pressure damage to their skin. Daily records showed the condition of people's skin was monitored when creams were applied to protect them against pressure damage. Air mattress pressures were checked and recorded to ensure they were correct for the person's needs.

As far as we could ascertain from incident and accident records, the service met its statutory obligations to inform the local authority safeguarding team and the Care Quality Commission of all notifiable incidents. Incidents and accidents were investigated and action plans put in place to minimise the risk of recurrence.

Staff knew what to do in emergency situations. People's files contained personal emergency evacuation plans which described the measures staff had to take to support them to remain safe. For example, in the event of a fire. The registered manager and members of the provider's senior management team carried out regular health and safety checks. The service had a comprehensive range of health and safety policies and procedures for staff to follow.

People received their medicines safely from staff who were trained and competent to administer medicines. The qualified nurses were responsible for administering people's medicines. Senior care staff were also trained to support the nurses when people needed additional time and support with taking their medicine. We observed nursing staff conducting the medicine rounds and saw people were given their medicines in a safe, considerate and respectful way.

The service had a recently introduced a new electronic medicine administration record system (eMAR). The registered manager said there had been some initial teething problems but overall it made the administration of medicines more accurate and safe. For example, if a nurse attempted to administer the wrong medicine, or to administer a person's medicine at the wrong time of day, the system sounded an alert and an error message appeared on the screen.

Medicines were stored safely in locked metal medicine trolleys which were kept in locked rooms when not in use. There were also suitable arrangements for medicines which needed additional security or required refrigeration.

There were infection control and prevention measures in place to protect people from the risk of infection. There were sufficient supplies of personal protective equipment (PPE) for staff to use, located around the premises. We observed staff wearing the appropriate protective aprons and gloves when providing personal care and when preparing or handling food. There were also notices around the home advising staff about how to maintain a safe level of hand hygiene. A member of staff was the designated infection control champion for the home and advised other staff on infection control matters.

The home was well maintained and appeared clean and tidy throughout. There were clear housekeeping schedules and we observed regular cleaning of the premises during our inspection.

Good

Is the service effective?

Our findings

People told us they thought the nursing and care staff were good at providing the care and support they needed. One person said "Everything is perfect here. The staff are brilliant. I've got no complaints". Another person said "They are very good with me. I need two staff and a stand aid to help me get into my wheelchair. They seem to have everything I need here. The chef is wonderful, I'm on a diet but I'm never hungry".

People's needs were fully assessed prior to moving to the home and then regularly thereafter. This ensured people's changing care needs were understood and met. Appropriate equipment was also in place as needed. For example, people at risk of pressure damage to their skin had special pressure relieving mattresses and the home was equipped with assisted bathing facilities for people with mobility needs.

People were supported to maintain good health and wellbeing. There were qualified nurses on each shift to ensure people's clinical needs were met. Local GPs, an optician and a chiropodist visited the home on a regular basis. People's care records described their health needs and any risks associated with it. Information was provided on the action needed to maintain people's health, including access to external health care professionals when needed.

The nurses were responsible for reviewing and updating people's care plans and for recording any changes in people's needs, risks or care. This information was also discussed at shift hand-overs to ensure all staff were aware and up to date with people's current needs. Where appropriate, people's relatives were informed of changes in their relative's health needs and they were involved in discussions about their care.

Staff received training to ensure they had the knowledge and skills to provide effective care in line with current best practices. Training included: safeguarding, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, first aid, infection control, fire safety, moving and handling, food hygiene, dementia and challenging behaviour. More specialist person specific training was also provided as needed to meet people's individual needs.

The provider organised a company-wide training programme and ran courses at the different homes in the group. Training records showed staff were generally up to date with their training and newer staff were booked onto the relevant training courses. The provider also supported staff with continuing training and development, including vocational qualifications in health and social care.

Newly appointed staff completed an induction training programme and worked alongside more experienced staff until they were confident and competent to work alone. The Care Certificate had been introduced as part of the induction programme. The Care Certificate covers an identified set of standards which health and social care workers are expected to adhere to.

Staff said they all worked well together as a supportive team to provide effective care and support for people in the home. People's individual care and support needs were regularly discussed at shift hand-overs and staff meetings. Staff told us they felt very well supported by their colleagues, senior staff, and the registered

manager and deputy. They received at least four individual staff supervision sessions per year and had an annual appraisal meeting. These meetings offered staff a regular opportunity for a review of their performance and any personal training or development needs.

Staff received training and had an understanding of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. People can only be deprived of their liberty to receive care and treatment which is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found staff knew how to support people to make decisions and knew about the procedures to follow where a person lacked the capacity to consent. This ensured people's rights were protected. Care plans recorded discussions with people's relatives and any decisions made in their best interest. This included Do Not Attempt Resuscitation (DNAR) decisions. There were no current DoLS authorisations in place but a DoLS authorisation had previously been obtained for a former resident of the home. This showed the service knew how to follow the requirements in the DoLS.

People were supported to have sufficient to eat and drink and to maintain a healthy diet. People's nutritional needs were assessed and staff were knowledgeable about people's dietary needs and preferences. For example, the chef controlled portion sizes and calorie intake for people assessed as needing to lose or gain weight. People who were at risk of malnutrition received fortified diets and were weighed regularly to monitor their body weight. Modified low sugar diets were prepared for people with diabetes.

The chef told us they worked to a four weekly meal menu which was discussed and agreed at the 'residents meetings'. The activities co-ordinator visited each person in the morning to explain the day's menu choices and ask for their individual meal choices. They said "This is just to get a rough idea of the numbers but people can change their minds if they want to. Also they can choose something else if they like". For example, we observed one person chose an omelette in preference to the day's meal choices. People told us they also had a choice of breakfasts and suppers. Various drinks and snacks were also available throughout the day.

The chef said, as far as possible, they wanted everyone to be able to enjoy the same type of meal choices and not to feel excluded. For example, the menu choices were adapted for people with special dietary needs. Artificial sweeteners were used rather than refined sugar for people with diabetes. Cream or skimmed milk was used for people who needed to increase or reduce their calorie intake.

We observed the lunchtime experience in the home's large L shaped dining room. There was plenty of space, dining tables and natural light. Each table was laid out with cutlery, drinking glasses, condiments and paper napkins. People could either sit on the dining room chairs or alternatively there was enough room for people to be positioned at the tables in their wheelchairs. Menus provided a choice of two meals, vegetables, and desserts. Other alternatives were also available on request. People were offered a choice of drinks including different flavours of squash, fruit juice or a hot drink if they preferred.

Most of the people were able to eat their meals independently. We observed staff checking if people were

OK and asking them if they wanted any assistance; such as help with cutting up their meal into more easily manageable pieces. We observed the activity co-ordinator supported one person who was unable to eat their meal independently. Once everyone was seated, staff were attentive, friendly and patient when serving people with their meals. The meals looked appetising with good portion sizes. People appeared to enjoy their meals and there was little wastage left on people's plates at the end of the lunch period.

It took some time for staff to get everyone seated at the tables before they started serving people's meals. This was because staff were assisting the large proportion of people with mobility needs to the dining room. We have already commented on the deployment of sufficient staff under the Safe section of this report. However, we found people's nutritional needs were being met and, once everyone was seated, the overall lunchtime experience was good.

We recommend that the service gives consideration to ways of improving the mealtime experience in order to reduce the delay in people receiving their meals.

The buildings and environment were suitable for people's needs. The premises were adapted for wheelchair use and there was a wheelchair accessible lift to the first floor. The home was organised into three units and all of the bedrooms had ensuite WCs and wash basins. Each unit also had a communal bathroom with assisted bathing facilities. The bedrooms in the Parkside unit also had their own ensuite wet rooms.

There were three communal lounges on the ground floor designated as the main lounge, an activities lounge and a quiet lounge. There was also a large dining room big enough to seat all of the people in the home, if they so wished. The accommodation was spacious, clean and well maintained throughout. Outside was a large secluded courtyard/garden with hard standing patios, plant beds and garden furniture for use by people who lived in the home and their visitors.

Good

Is the service caring?

Our findings

People told us the regular care staff were very good and caring. One person said "Everyone's lovely and they all muck in. I'd recommend this home to anybody. The manager is brilliant, she loves us all". Another person said "The carers are all very nice but suddenly they leave to go somewhere else. We get a lot of agency staff and they are not the same as our regular staff".

The registered manager told us there had been staff turnover over the last 12 months but the reliance on agency cover had now reduced and there was an ongoing recruitment drive. Where possible, existing staff were offered additional hours and shifts. The registered manager also covered some of the nursing shifts herself to help out when needed. Agency staff were only used as a last resort if no other cover was available.

We observed people looked relaxed and comfortable with the staff who supported them and the atmosphere in the home was generally calm. All of the people looked well cared for and were appropriately dressed in clean clothing. A member of staff said "I look on people as if they were my own mum or dad. I want them to have the best care no matter what".

Staff displayed a friendly, kind and caring approach toward the people in the home. We heard staff speaking with people in a polite, clear and kind manner. For example, we heard a member of staff explaining to a person that a previous resident they were enquiring after was no longer living at the home. The person said "Oh sorry, I get muddled" to which the member of staff replied "That's alright my love".

We observed other examples of staff caring for people in a supportive and considerate way, such as when they were supporting people to move around the home and when assisting people at mealtime. For example, we heard a member of staff speaking with a person who was undecided about whether to have a particular meal for lunch. The member of staff said "Would you like a little bit to try first and if you like it I'll get you some more". Another person with mobility and sensory disabilities told us "I'm going [abroad] on holiday and one of the girls [meaning a member of staff] is taking me".

People were encouraged to make their own decisions, as far as they were able to. We observed staff offered people options to choose from and then acted on the person's wishes. We heard staff asking people about their daily choices and no one was made to do anything they did not want to. Staff appeared to have a good understanding of each person's needs and preferences. They were patient and persevered to ensure they understood people's wishes, particularly when people were unable to fully express themselves.

Staff respected people's privacy and dignity. Personal care was only provided in the privacy of people's bedrooms or in the home's assisted bathrooms. Staff ensured doors were closed and curtains or blinds drawn, as necessary. Staff respected people's privacy by knocking on people's doors and waiting until they were invited in. We observed staff assisted people in a discrete and respectful manner, for example, when people needed assistance to use the facilities.

Staff spoke respectfully about the people they supported and were careful not to make any comments

about people of a personal or confidential nature in front of others. This showed staff respected people's confidentiality.

People were supported to maintain relationships with their families and friends. People told us their relatives could visit them without any unnecessary restrictions and they were made welcome when they visited.

Information about people's end of life preferences, and any spiritual or religious beliefs, was recorded in their care plans. The service liaised with the local palliative care team and other health professionals to deliver end of life care where this was appropriate. One of the care staff told us "I am the home's champion for end of life care and I've done a distance learning course on this. I let other staff know about anything I find out". The member of staff said they offered advice or support to other staff when they needed or wanted any help.

Requires Improvement

Is the service responsive?

Our findings

We found inconsistencies in people's care records and in the frequency of care plan reviews. For example, one person's daily care record was not completed when we checked at supper time, and there was no daily record for the previous day. The person's monthly 'review and audit record' showed certain aspects of their care had been reviewed on 13/08/2016 and 03/09/2016 but there were no records at all for the months of October or November. Other important reviews, such as the person's falls risk assessment and air mattress pressure checks were up to date. This showed an inconsistency in the completion of their care records.

Another person's 'person centred assessment' quarterly review record was only partly completed. These assessments are important to ensure people's health and well-being is monitored so that any changes in health can be acted upon. Records showed the person's assessments, numbered 1 to 10, were reviewed on 07/11/2016. But the remaining assessments, numbered 11 to 25, were last dated 03/07/2016 and there was no record of a later review. Similarly, the person's monthly 'mobility and pressure risk' assessment form stated the next review was due on 09/09/2016 but there was no record of a review in September or on a later date. Although we did not see evidence of inappropriate care, the failure to keep up to date records meant there was a risk people may not have received care in line with their current needs.

The failure to maintain an accurate, complete and contemporaneous record for each person was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

We spoke to the registered manager and the quality performance manager about the inconsistencies we found in the care records. They accepted our findings and expressed their disappointment, as they said they had put a lot of effort into promoting the importance of person centred care planning with staff. The registered manager said the qualified nurses were responsible for updating people's care plans. The nurse in question had carried out an audit which stated the care plans were complete and up to date, which our evidence showed was not the case. The nurse was no longer working at the service but the registered manager undertook to carry out a detailed review of all care plans to check they were current and complete.

People's care needs were assessed and comprehensive care plans were in place to provide staff with the necessary information to respond to people's individual needs. Care plans described people's individual care and support needs, decision making and communication abilities, and the things they enjoyed or disliked. Although the service adopted a person centred approach to care planning more could be done to ensure a more consistent person centred approach by every member of staff.

We observed some staff were better at engaging with people than others when responding to their needs. For example, some staff tried to chat to people about their individual interests while they were providing support or other assistance. Whereas some other staff were more task oriented and did not always take the opportunity to engage with people socially when helping people to move around the home or bringing people their drinks and snacks.

People could make certain choices about how they spent their days. For example, they could spend time in the privacy of their own rooms or in the communal areas of the home. People's rooms were furnished and decorated to suit people's individual tastes and choices. The service provided certain opportunities for social and recreational activities and some of the people told us their relatives took them out.

However, on the whole, people told us they would like more activities to meet their social and recreational interests. One person said "We get taken out in the minivan sometimes, but I've not been out too much. They are too busy". Another person with mobility needs said "They do things in the house but they don't interest me. There's not a lot going on with activities. There's a beach at the end of the road. It would make a world of difference if I could be pushed out there".

We spoke to the home's full time activities co-ordinator, who was very visible around the home and clearly knew all of the people well. They were highly regarded by people in the home. One person said "[Activities co-ordinator's name] is very good and she does her best". The activities co-ordinator told us she tried to do one to one activities with people who had the greatest dependency needs, or received no visitors, in the mornings. This included individual chats, playing card games like snap, reading and reciting poetry. She also spoke with every person in the home each day "Even if only for five minutes" to discuss their meal choices.

In the afternoons she tried to do at least one group activity such as reminiscence sessions, games like 'I spy', playing catch with a soft ball, or preparing and icing cakes. She provided a jigsaw or 'twiddle mitts' for people with early signs of dementia, to occupy themselves when they were unable to participate in the group sessions. Some people with a dementia find 'playing' with objects such as these helps to reduce their anxiety and promote a feeling of calm.

When the weather was good she sometimes arranged trips to the local park or picnics in the home's garden. Every Friday external singers visited the home for a sing along session, every fortnight she organised a bingo session or some other card game or group crafts. Once a month representatives from a local church visited the home and delivered a service with communion. A person visited on a monthly basis to present slide shows on different topics or to organise quiz sessions. Annual events were also arranged such as a Halloween and Guy Fawkes night, and a pantomime at Christmas.

The activities co-ordinator said she felt people had missed out a bit on trips this year for various reasons. She said she had been off work with an injury for six weeks; there had been a recent diarrhoea and vomiting outbreak in the home; and the assistant activities co-ordinator post was currently vacant although it was now out to advert.

People and staff told us the current registered manager, and the deputy manager, were very accessible, approachable and responsive. They said they could go to the registered manager or their deputy and they would try to resolve any issues or complaints appropriately and promptly.

The provider had an appropriate policy and procedure for managing complaints about the service. This included agreed timescales for responding to people's concerns. The Provider's Information Return stated the service had managed four complaints under their formal complaints procedure In the last 12 months. These related to the length of time taken to answer people's call bells. In response to the complaints a new staff pager system had been introduced; staff were allocated specified areas of the home to cover; and new staff were recruited. However, as detailed under the Safe section of this report, the service had not yet satisfactorily resolved this issue.

Requires Improvement

Is the service well-led?

Our findings

The provider had a quality assurance system but this had not operated effectively in terms of implementing the necessary improvements to address issues detailed earlier in this report. For example, internal audits of care plans stated they were complete and up to date, but we found inconsistencies and missed care plan review dates. People's call bells were not always responded to in a timely manner and the continual loud ringing sound was intrusive and disturbing. Call monitoring records were not routinely audited or analysed; and effective action had not been taken to resolve this area for improvement. Both of these issues had previously been identified by the provider's quality monitoring systems, but the action to-date had not proven to be effective.

The provider's quality assurance system included in-house monthly audits of many key aspects of the service. Audits covered care plans, medicines, nutrition, wound management, and the environment. The provider's Quality and Performance Manager also carried out a service review of the home every couple of months. The home owner and other senior managers also visited periodically. The registered manager was responsible for drawing up and implementing an action plan to address any issues, for example staff recruitment, and this was followed up at the next service review. Although certain actions had been taken in response to identified areas for improvement these had not always been sustained or had not been fully effective in resolving the concerns.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

The home was managed by a person who had recently been registered with the Care Quality Commission as the registered manager for the service. They had worked at the home for some time, in the capacity of deputy manager, but had recently been appointed as the permanent replacement for the previous manager of the service. The new registered manager told us their service philosophy was "For this to be a clean, safe, happy home from home. To be one big happy family of staff and residents. To be somewhere I would be happy for my mum to stay and to be well respected within the community. Somewhere people want their family to come to".

The new registered manager was highly regarded by people who lived in the home and by the staff. One person who lived in the home said "I would say [registered manager's name] is a good manager all round. When she is there you know it's all under control". A member of staff said "[Registered manager's name] is brilliant, she'll help you no matter what. The deputy is the same". Another member of staff said "[Registered manager's name] is approachable and the most supportive manager I've had. She's so hot on things, in general everything runs smoothly".

From our discussions with the staff, the registered manager and the quality performance manager it was evident that the new manager had already made improvements to the way the service was run. For example, one person who lived in the home told us the registered manager had "weeded out" most of the staff who were not very good and "The good ones have been retained or stayed". Several new staff had

recently been appointed and were booked onto training courses. Although some progress had been made there were still areas that required improvement.

The service had a clear staffing structure, with clear lines of reporting and accountability; from care assistants, to senior care staff and nurses, to the deputy and registered manager, and the provider's senior management team. We observed the registered manager was very visible around the home and provided clear leadership. The nurses and the care staff understood their respective roles and responsibilities. Decisions about people's care and support were made by the appropriate staff at the appropriate level. Overall, staff appeared well motivated and they were committed to meeting people's care and support needs.

To the best of our knowledge, the registered manager has notified the Care Quality Commission of all significant events and notifiable incidents in line with their legal responsibilities. The provider and the registered manager promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

People had opportunities to give their views on the service through routine conversations, care plan review meetings, and bi-monthly 'residents meetings'. People told us their relatives were always made welcome when they visited and, where appropriate, were also invited to be involved in care planning and any discussions about service developments.

The registered manager participated in forums for exchanging information and ideas and fostering best practice. These included service related training events, conferences and relevant online resources for obtaining information and advice. The registered manager attended the provider's six weekly 'home managers meetings' and various multi-agency meetings with health and social care professionals. Staff meetings were held to discuss and disseminate information and ideas and to keep staff informed about service developments. These forums helped the service to keep up to date with current care practices.

The service had links with the local community, including a local church, and staff supported people to participate in certain social and recreational activities within the home and in the local community. The service also worked in close partnership with local health and social care professionals; and relevant specialist support and advice was sought when needed. The service cooperated with other agencies to help ensure people's health and wellbeing needs were met.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to maintain an accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c). The system to assess, monitor and improve the quality and safety of the service was not operating effectively. Regulation 17 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of people using the service at all times. Regulation 18 (1).