Guild Care

Caer Gwent

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 23 and 24 February 2017 and was unannounced.

Caer Gwent provides nursing care and accommodation for up to 61 older people with a variety of health needs. At the time of our inspection, 59 people were living at the home. Caer Gwent is a large home, situated away from the road and close to Worthing town centre. The home is divided into several units or suites comprising: Amberley, Goodwood, Arundel, Petworh and Parham. Each suite contains bathrooms, communal sitting and dining areas. A library room on the ground floor has a range of books for people to borrow. All bedrooms have en-suite facilities. There is a separate two bedroomed apartment serviced by a separate lift. The home has gardens at the rear which are accessible to residents and off-road parking.

A registered manager was 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.

People and their relatives felt that Caer Gwent provided a safe environment. Staff had been trained to recognise any signs of potential abuse and knew what action to take. People's risks were identified, assessed and managed appropriately, with clear guidance for staff on how to support people safely. Staffing levels were sufficient to meet people's needs and safe recruitment practices were in place. Medicines were ordered, administered, stored and disposed of safely. The home was clean and hygienic.

Staff had been trained in a range of areas and new staff following the Care Certificate, a nationally recognised qualification. Registered nurses completed specialised training. Not all staff had received regular supervision in line with the provider's policy, that is, three supervisions per year and an annual appraisal if required. The registered manager was aware of this and that this was an area that required improvement. Staff felt supported and attended team meetings and some group supervision meetings were held. Staff had a good understanding of the legislation relating to mental capacity and Deprivation of Liberty Safeguards and put this into practice. People were supported to have sufficient to eat and drink and the lunchtime experience we observed was a relaxed affair. People were supported to have good health and had access to a range of healthcare professionals and services. Rooms were personalised and people commented on the comfort of their rooms.

Positive, warm and caring relationships had been developed between people and staff. There were several instances that were observed when staff responded to people's needs in a sensitive and compassionate way. People and their relatives were involved in decisions relating to their care. People were treated with dignity and respect.

Care plans provided detailed information and guidance to staff on how to support people in a person-centred way. People's personal histories were recorded. A range of activities was organised by the activities

co-ordinator and some external visitors provided musical entertainment. Complaints were managed in line with the provider's policy.

People and their relatives were encouraged to feedback about the quality of the care delivered and residents/relatives' meetings were organised. A newsletter was published to update people on what was happening. Staff felt supported by the registered manager and enjoyed working at Caer Gwent. High quality care was delivered and a range of audits was in place to measure and monitor the service overall. However, the registered manager had not notified the Commission of three significant events and these were discussed at the time of our inspection.

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.

People felt safe living at the home. Staff knew what action to take if they suspected people were at risk of abuse and had been trained appropriately.

People's risks were identified, assessed and managed safely. Clear guidance was in place for staff.

Staffing levels were sufficient to meet people's needs.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was generally effective.

Some staff did not receive regular supervision meetings in line with the provider's policy. This had been identified by the provider as an area for improvement.

Staff completed a range of training and were encouraged to study for external qualifications.

Consent to care and treatment was sought in line with legislation and guidance. Staff understand the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

People were generally complimentary about the food on offer. They had access to a range of healthcare professionals and services.

People were happy with their rooms and had items of importance to them on display.

Is the service caring?

Good

The service was caring.

People spoke highly of the staff that cared for them. Warm, caring relationships had been developed between people and

staff.

People and their relatives were involved in decisions relating to their care.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans contained detailed information about people's care needs, including their personal histories.

A range of structured activities was organised for people living at the home.

Complaints were managed satisfactorily and in line with the provider's policy.

Is the service well-led?

Good

The service was well led.

People and their relatives were asked for their views about the home.

Staff felt supported by management.

Notifications relating to three instances had not been notified to the Commission as required. This was discussed with the registered manager.

A range of audits was in place to measure and monitor the care delivered. Actions were identified of any improvements that were needed.

Caer Gwent

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 23 and 24 February 2017 and was unannounced.

One inspector and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience at this inspection had expertise in older people and dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including five care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with 10 people living at the service and spoke with five relatives. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, two registered nurses, the receptionist, a volunteer and three care staff.

The service was last inspected on 30 December 2015.

Good

Is the service safe?

Our findings

People told us they felt safe living at Caer Gwent. One person referred to staff and said, "You feel that you can completely trust them". Another person told us, "I can speak to any one of them if I had to". A relative commented, "I feel that [named family member] is completely safe in their hands. Where she was before you could tell they were nervous about certain things like hoisting and it always worried me. I don't here and they are very competent". People were asked if they felt safe in a questionnaire which the provider had sent out. One person had written, 'Always people around. If there was an emergency, I would be looked after'. Staff had been trained in safeguarding procedures and knew what action to take if they suspected people were at risk of abuse. Staff told us about the types of abuse that might occur such as financial, emotional, physical and sexual. The local authority's safeguarding policy and guidelines was available for staff to consult in the registered manager's office. One member of care staff said, "If you suspect abuse, whether staff, a family member or another resident is abusing another person, then you have to flag it up to the manager. It's your duty to protect people".

Risks to people were managed so they were protected. Care records contained a variety of risk assessments which showed that people's risks had been identified and assessed as needed. Risk assessments contained detailed information and guidance to staff on how to support people safely. Risk assessments were in place for mobility and falls, tissue viability, moving and handling and nutrition. For example, in one person's care record we read that they were at 'medium' risk of falls. The falls risk assessment included the person's medication, psychological and cognitive condition. The person's mobility had deteriorated over time so that they now required to be hoisted; their care record had been reviewed and stated that two care staff were needed to support them. People's risk of developing pressure ulcers had been assessed using Waterlow, a tool specifically designed for this purpose. We looked at wound care charts and these recorded how often people's pressure areas were checked and, if needed, dressings changed. People's risk of malnourishment was also assessed and their weight was monitored. One person told us, "They were a bit worried about me losing weight because I had been poorly and in hospital. I was so happy to be back, just like coming home. They weigh me every day and I'm putting a bit of weight back on now. I feel I'm getting stronger again with their help". A registered nurse told us that risk assessments were reviewed monthly and records we checked confirmed this. Accidents and incidents were reported and recorded appropriately with the date, time, person's details, location, injury if any, first aid, medical treatment, action and how reoccurrence would be prevented. People had access to call bells or wore pendants which enabled them to call for staff assistance. People told us that their calls bells were responded to promptly. One person said, "Yes, it's like they're at your beck and call!"

We discussed the staffing levels with the registered manager who told us they were supported by two deputy managers. At the time of our inspection, 59 people were living at the home. Two registered nurses were on duty during the day, with one senior care assistant and 12 care staff (six staff upstairs and six staff downstairs). In addition there were domestic staff and staff who undertook non-care duties, such as laying tables, helping with meals and refreshments and some cleaning duties. At night, one registered nurse was on duty, supported by a senior care assistant and five care staff. We checked staffing rotas over a period of four weeks and these confirmed that staffing levels were consistent over this time period. Where needed,

agency staff would cover known absences or staff annual leave. Staff we spoke with felt there were sufficient staff available to meet people's needs safely. One staff member said, "It's a lot better now. We have the odd agency worker and they're good. If staff are sick we use bank staff or staff can work extra shifts if needed". They added, "It can get tough on the floor, especially when you're short staffed. [Named registered manager] knows what it's like and she will muck in". A registered nurse felt there were sufficient staff and said, "Yes, it's okay. Sometimes if people are sick it can be difficult, but [named registered manager] is very helpful".

Safe recruitment practices were in place. Staff files we checked showed that potential new staff had completed application forms, received a job specification, two references had been obtained to confirm their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting.

People's medicines were managed so they received them safely. We observed a registered nurse administering medicines to people from a medicines trolley which was secured to the wall. Medicines were stored for each person in a dedicated box which helped to ensure that people received the medicines prescribed only for them. We observed the registered nurse waited patiently with people as they took their medicine. To one person they said, "Are you okay to take them?" as they kneeled down next to the person at the lunch table. The registered nurse took the Medication Administration Records (MAR) with them when they administered people's medicines. The MARs were not left unattended at any time, thus ensuring people's information was kept confidential. The medicines trolley was locked between the administration of each medicine. We were shown how medicines were stored in a medicines room and that medicines which required refrigeration were stored at the correct temperature. Medicines audits were completed as needed. It had been identified recently that the administration of medicines by registered nurses could be a time-consuming exercise. As a result, the provider had taken action so that now senior care staff , who had received appropriate medication training, could assist in the administration of medicines, overseen by the registered nurses. This meant that people would receive their medicines as prescribed and without undue delay.

We observed that the home was clean and hygienic. One person said, "I never worry about hygiene or that I'm going to pick up an infection. It's spotless". Another person told us, "It's as clean as you'd expect a hospital to be. There's always someone doing some cleaning".

Requires Improvement

Is the service effective?

Our findings

People received effective care from staff who had completed training in a range of areas. The staff training plan showed that staff had received training in food safety, nutrition and hydration, first aid, moving and handling, safeguarding, health and safety, fire safety, infection prevention and control and mental capacity. Dementia awareness training formed part of the safeguarding module. Some staff were 'Dementia Friends' which meant they had a good understanding of what it was like for a person living with dementia. Registered nurses had completed specialised training in catherisation, defibrillator, venepuncture, tissue viability, anaphylaxis, wound care and medication. Yearly refresher training was required in moving and handling and health and safety. Staff were encouraged to study for qualifications such as diplomas in health and social care. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. New staff completed an induction programme and a period of work shadowing with experienced staff.

According to the provider's policy, staff should receive three supervisions each year and, if appropriate, an annual appraisal. However, not all staff had received regular supervisions in line with this policy. The registered manager was aware of this issue and told us they were taking steps to improve this. We asked care staff about their supervision. One confirmed they had attended a supervision meeting a couple of months ago. They said, "We talked about equipment, whether I had everything I needed, how we're getting on and areas for improvement". They added they had received two supervisions since they came into post some 18 months previously and felt they would have found more regular supervisions helpful. They said, "It makes such a difference if you feel appreciated". Where needed, staff had recently completed annual appraisals, but at least 10 care staff had not attended supervision meetings with their line managers in 2016. The provider had completed an audit in January 2017 which referenced staff supervisions and stated, 'Staff spoke of supervisions, but this wasn't always consistent'. The provider had identified this as an area for improvement. Some staff supervisions took the form of observations of their work and appearance. Three group supervision meetings for care staff had been held during 2016, including a separate group supervision meeting for senior care staff. Staff meetings also took place and we saw records which confirmed meetings had taken place for housekeeping staff, laundry staff, senior care staff, night care staff and day care staff. Meetings for 2017 were planned and dates shared with staff.

There was no evidence to suggest the lack of supervision meetings had impacted on the care people received from staff and staff did not tell us they felt unsupported. One person told us, "I feel staff are incredibly competent, nothing seems to faze them". A relative referred to staff and said, "I've noticed how consistent they all are in how they look after [named family member] at all times of the day and night. They all know what they're doing".

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. We asked care staff about their understanding of mental capacity and the MCA. One staff member said, "People don't always know about choices, but you still give it to them". Another staff member said, "You've got to figure out whether a person knows what they're talking about and help them make choices". A third member of staff explained mental capacity as, "To give the resident the choice of what they want to do and making sure they have the capability to make their own choices, even if you think they've made the wrong choice or decision".

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 and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that DoLS had been applied for where people had been assessed as lacking capacity to make informed decisions. At the time of our inspection, all DoLS were still awaiting assessment by the local authority.

People were supported to have sufficient to eat and drink and were encouraged to maintain a balanced diet. People consistently told us they had drinks to hand and we observed this in practice. One person said, "I've always got my 'fizzy whizzy'!", making reference to their preference of sparkling water. The provider had a contract with an external organisation who were responsible for catering at Caer Gwent. The registered manager told us that the chef met regularly with people to obtain their feedback about the meals on offer. The chef had a profile of each person's dietary needs and catered for these appropriately.

People could choose where they wished to eat their lunch, in their room, from an overlap table in a communal area or in dining rooms located on the ground and first floor. Most people felt the food on offer was good, that it was served hot and they had enough choice. One person, who required a diabetic diet, said they only had jelly each day. They explained, "I'd love some diabetic ice-cream at least". Another person commented they would enjoy a fresh piece of fish on occasion, rather than frozen.

We observed the dining experience at lunchtime. The atmosphere was calm and relaxed with people chatting around small tables. Tables were nicely laid with tablecloths, napkins, cutlery, glasses, condiments and fresh flowers. Where people chose to eat their meals off trays, these were nicely presented with table linen. A wide variety of juices were on offer and people could also choose to have an alcoholic beverage, such as wine, lager or sherry. The meal on offer comprised three courses. Even if people had 'pre-ordered' their meal, they were still offered the opportunity to change their minds as the meal was served. People had various drinking vessels available according to their needs and were asked by staff if they required any assistance. One person was offered a plate guard, to prevent their food sliding off the plate, and they felt this was a helpful and good idea. People who required one-to-one support from staff were helped gently. Care staff supporting people maintained good eye contact and offered intermittent drinks, checking with people that they were ready for the next mouthful of their meal. During the mealtime, one person asked for staff assistance to go to the toilet. This was responded to promptly and discreetly by staff. People were asked if they wished to wear protection to keep their clothes clean whilst they were eating. We heard one member of staff say, "Can I just pull that up for you a little bit, but I know you don't like it round your neck". Staff were very responsive and sensitive to people's needs. We observed the registered manager was also helping people with their meals in the dining room. The provider had sent out a questionnaire to people to ascertain their views about the meals on offer. Some people had stated they were not happy with the food, but were unclear as to why this was the case, making it difficult for their concerns to be followed up.

People were supported to maintain good health and had access to a range of healthcare professionals and

services. One relative said, "[Named person] has really objected to wearing hearing aids, but they have been so good and have used their wheelchair adapted car to take us to appointments". Another relative commented, "The chiropodist comes regularly and is a real charmer, she loves him. Then the hairdresser is here too". A third relative said, "[Named family member] had a chest infection and they kept a close eye on things. They called 999 and she was admitted to hospital. On her return, which was late at night, even though they were stretched for staff, she got a lovely warm greeting and welcome back. They couldn't do enough for her". Care records showed that people had regular access to healthcare professionals and appointments. For example, people saw opticians, chiropodists and GPs. One person was referred to a speech and language therapist as they had difficulty in swallowing. A registered nurse told us, "Every two weeks a GP will visit. We put together a list of residents to be seen". Where people required to be seen by a GP more urgently, then this was arranged straight away.

We observed that people's individual needs were met by the design and decoration of the home. Rooms were personalised with memorabilia and photos on display. One person told us how important it was to have all her hand knitted dolls around, whilst another commented that she loved the fresh flowers in her room. A third person said, "I enjoy the parrot coming into my room, we chatter away!" People commented on the comfort of their beds and that they felt they had all they needed in their rooms. A fourth person told us, "I was having problems with the light shining in my eyes and straight away they changed the bulb and the lampshade for me". However, a fifth person told us they did not like their curtains and that they had turned over their bed cover as they did not like the pattern.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. When communicating, we observed staff had good eye contact with people, gave them explanations where needed and offered a gentle arm around a person's shoulder or held their hand whilst supporting them.

We observed one person, who had arrived the day before, was a little confused and asked about their partner. The registered manager came over to them, calmly and gently reassured the person that their partner would be coming later or, if not, tomorrow and that they would see them again soon. The registered manager spoke in a very soft and reassuring tone, crouched down to the person's level and gave good eye contact. The conversation did not end until the registered manager could see the person understood and was reassured. Two other people had recently moved to Caer Gwent from one of the provider's other homes. One person said, "It seems so big and busy compared to [named other home]. I feel a bit lost but everyone is so nice". The second person said, "It's not as cosy or homely and I loved all the staff there [at previous home], but they've been to see me. I'm sure I'll be all right here, I've just got to get used to it. They've been very welcoming and nice here".

We saw one person came out of their room and into the corridor where a member of the housekeeping staff was cleaning. Immediately, the staff member greeted the person and asked them whether they needed anything. The staff member said, "Hello [named person]. Are you all right?" The person responded, "My mouth is ever so sore just in the corner (pointing to the corner of her lips)". The staff member said, "Oh yes, I can see. I'll go and ask the nurse for you. Do you want to sit comfortably in your chair and I'll be back in a minute". A few minutes later the staff member returned and said, "The nurse is going to come and see you. In the meantime, she's suggested I pass you your pot of Vaseline to ease it, is that okay?" The staff member then handed the little pot of balm to the person and a little mirror in case she needed it. The person responded, "Oh that's better", after she had applied the balm. We observed several occasions when staff checked on people's comfort, asking if they wanted their feet up, were they warm enough, did they want more cushions, did they need help sitting more upright and other caring comments. For example, "Are you all right, would you like me to help you?", "Let me know if you need me" and "Hello [named person]. I'm off to Greece soon and I know that's your favourite place".

In a questionnaire that the provider had sent out to people, one person stated, 'I feel comfortable all round the home. The staff are nice and they always offer assistance. I feel at home here; it's really lovely'. Some staff felt they did not always have as much time as they would have liked to chat with people. One staff member said, "Sometimes residents just want a chat. I might spend time and have a little chat with people on my break". Another staff member told us that for the majority of time they felt they did have time to spend chatting with people. They added, "We have a keyworker system. We're supported to have an hour with people each week". They talked about the shopping they did for people, sometimes in their spare time. A third staff member said, "I try and have a chat with people while I'm doing personal care. Sometimes it would be nice to have a chat of 10 – 15 minutes, I try!".

People were supported to express their views and to be involved in making decisions about their care,

treatment and support. A member of care staff said, "I try and involve people. It's their choice, what they want to do or wear. I try to encourage independence". A registered nurse told us, "We send emails or call relatives and sometimes relatives visit. We try and have a conversation with people and sit down with people and relatives. We ask if they're happy with the care provided and if residents are able, then they're involved too". A relative told us, "We go through [named family member] care plan together from time to time and they do know her very well". Another relative said, "What I'm impressed by is that they make [named family member] feel in control".

People were treated with dignity and respect. When staff were supporting people with their personal care, notices were placed on their bedroom doors which stated, 'Care in progress' to ensure people's privacy was maintained. We asked staff how they would deliver personal care. One staff member said, "I would cover them up so they don't get cold. I always ask them whether they want their face washed". They said they encouraged people to be as independent as possible, "It's difficult sometimes because you just want to do it. Sometimes I feel I don't have time if people want to talk". Another staff member said, "I treat them as if they were my parents. I have a little conversation with them. Some people prefer to get up later" adding that people could choose whether to be looked after by male or female staff.

We observed little touches throughout the day that promoted people's dignity and choice. For example, as the mid-morning drinks were served, people were offered a choice of biscuits from the plate, along with cups and saucers and a side plate to use. People were also asked if they wanted any more. Hot and cold drinks were offered and people were asked whether they wanted sugar, how much milk and how strong they wanted their tea or coffee. We heard staff asking people if they were happy for them to move things, like their walking aid as one example. Staff gave the person an explanation of where it had been moved to, but that it was still within reach. We observed staff to knock on people's doors and ask if it was a good time to enter. People said, "Staff are so respectful in the manner in which they speak to you". A relative told us, "[Named family member] has been ill and spends most of her time in bed. I'm here such a lot so I notice how kind and gentle they are". Another relative said, "Privacy is very important to [named family member] and they don't force her to do anything she doesn't want to do. So if she chooses to stay in her room, they keep contact by popping in regularly".

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans provided detailed information about people in a person-centred way. The essence of being person-centred is that it is individual to, and owned by, the person being supported. A person-centred approach to care focuses on the person's personal needs, wants, desires and goals so they become central to the care process. People's needs take priority. Care plans documented information relating to people's personal care, mobility, continence management, skin integrity, nutrition, communication, mental cognitive behaviour, day and night care. A 'resident of the day' meant the person was weighed, had their observations completed (blood pressure, pulse and weight monitoring) and a deep clean was undertaken of their bedroom. Daily care records were completed which included the care people received, any skin pressure areas to be checked, turning charts, food and fluid intake, fluid output and bowel management. A registered nurse told us that the nursing staff were responsible for updating care plans and these were reviewed monthly. Each registered nurse had an allocation of people. We read, 'Care plans to be done on a monthly basis. Resident's next of kin to be contacted monthly and then documented'. Handover meetings were held between each change of staff shift. These were opportunities for people's care needs to be discussed and staff coming on shift to be informed of any updates.

People's personal histories were recorded in their care plans as well as information relating to their hobbies and interests. One member of staff talked about their keyworking role and that they were keyworker to two people living at the home. Part of the keyworker's responsibilities was to draw up a profile of the person they had been allocated, for example, the person's background, brothers and sisters, family history and employment. The member of staff told us, "As a keyworker you try to make sure they've got their toiletries or ask family to buy them". A keyworker would liaise with any relatives if a person needed new clothes or underwear. One relative said, "[Named family member] is very keen on her clothing and they always ask her and she's always in nice matching outfits. She also loves to smell nice, so she always has a little spray of perfume. Her hearing aids are in and they make sure her teeth are clean". People had the choice of whether they wished to be looked after by male or female staff. One relative told us, "I had to have a word as [named family member] has got more vulnerable. She didn't want male carers at night. She never minded before, but as things have changed, she doesn't mind during the day, but not at night. I spoke to [named registered manager] and it was dealt with immediately and that doesn't happen now".

An activities co-ordinator arranged a programme of structured activities and a printed copy of this schedule was shared with people living at the home. For example, in the week commencing Sunday 19 February 2017, the following activities were on offer: film shows, flute and operatic singing and musical entertainment provided from several visitors to the home. The piano lounge was utilised for morning and afternoon musical activities and the guitarist commented he had been asked to prepare some 1960s songs instead of songs from the usual 1930s and 1940s. The activities co-ordinator also organised other group activities such as physical exercises and Bingo.

People were encouraged to participate in activities, however, several people commented on the activities feeling they could cater more for their individual tastes. One person said, "I'd love to do card making, I'd

really enjoy that. I'm sociable, but not in a group". Another person said, "I'm not keen. I find some of the things a bit silly really, but I have a go at the exercises". A third person commented rather sadly, "I'd love a friend, a companion that lives here, someone to just have a chat and laugh with. It's very beautiful here, but that's cosmetic". A relative told us, "[Named family member] doesn't want to join in the lounge, but I asked if someone could just at least spend 10 minutes a day having a chat with her. It was going well, but it's tailed off now, so I've asked them again if someone could play Scrabble or even Bridge". Another relative said, [Named family member] is not at all musical and can't walk, so hates the thought of being dumped in there [piano lounge] without being able to leave".

A volunteer visited the home on a regular basis and told us she had a core group of people that she visited on a one-to-one basis. These tended to be people who did not want to join in with group activities. The registered manager said, "Residents are all individuals and we don't want to have a resident sitting in their room with nothing to do. We ensure they have company at any time of the day or night". An occupational therapy student had recently completed a project at the home which related to the organisation of one-to-one and personalised activities for people. This student had written a report on their findings, together with recommendations for the planning of future activities, which the registered manager was hoping to implement.

We asked people whether they felt their spiritual needs were catered for at Caer Gwent. One person said, "I used to enjoy Sundays, but the ministers have stopped coming. [Named visitor] might come in to do hymns. I can't get to church now, it's a shame". We asked the registered manager what arrangements were made to meet people's religious and spiritual needs. She explained that a priest used to visit every Sunday, but had stopped coming. The registered manager said they were looking into arranging for clergy to visit every Sunday; some people received Holy Communion on an individual basis.

Complaints were encouraged, explored and responded to in line with the provider's complaints policy. The policy stated that formal complaints would be acknowledged within three working days and a formal response would be issued within 14 working days. We checked the log of recent complaints. One concern had been raised by a relative through a questionnaire that the provider had sent out. The relative had commented they felt that their family member's care was not always personalised or delivered consistently. The registered manager had responded and told us they were working with this relative. The relative met with the expert by experience during our inspection and spoke positively of the care their family member received. Another relative had responded to the questionnaire saying, 'Staff are always helpful and will deal with any concerns'. The registered manager explained the importance of gaining feedback from people and their relatives and of working together to deliver high quality care. One person told us, "I'd definitely complain if I had to and speak to the manager".

Good

Is the service well-led?

Our findings

A positive culture was promoted that was person-centred, open, inclusive and empowering. Various comments from people included, "I've only been here a day, but I already like it, it seems well run", "I feel I could approach anyone and ask them anything" and "It's lovely, they can't do enough for you". Residents' meetings were organised with the last meeting held in February 2017. Items under discussion included: hot and cold drinks – what people liked, the new décor, activities, Christmas – how was it? and any other business. One person told us, "We have residents' meetings yes, but like everything here, it's my choice if I go or not and as I've no complaints and I'm happy, I don't tend to bother". A cheese and wine evening had been organised for people and their families in February 2017. A newsletter was produced recently which provided information about the building refurbishment, the closure of one of the provider's other nursing homes, residents and relatives' meetings, named nurse and keyworking arrangements and surveys.

The registered manager told us, "I've learned a lot from the residents because I've worked here so long. Residents have taught me compassion. I listen to people and learn from facial expressions and body language how they feel". A relative corroborated this by saying, "I was here for a while when [named family member] was ill and I stayed overnight. The manager wanted to make a bed up for me and was very attentive to my own comfort and rest. She made sure I had drinks and meals. She was very generous and I know where the tea and coffee machines are so I could help myself at any time". It was clear from our discussions about people that the registered manager knew everyone really well. We asked the registered manager about the culture of the home and she explained, "It's quite casual and whatever the residents need, we'll get it. We try and ensure their needs are met, that they have social interaction and are happy".

Staff felt supported by the registered manager. One staff member said, "It's a lovely place to work". Another staff member said, "I enjoy my job. I like running around and being busy. I love the residents, although it can be stressful when we're busy". A third member of staff, when asked what they felt was good about working at the home, said, "The staff, the residents. It's homely. It's not too regimental. You can be yourself and the residents appreciate you". Staff commented on the support they received. One said, "We laugh and have a joke with her [registered manager] but there's a line we respect". They added, "She knows her staff and if I'm having a bad day, she can sense it and ask me what's up. She's very approachable and understanding. She'll be honest with you". A registered nurse confirmed they felt well supported and said, "The manager and deputy manager are supportive and shift working is flexible".

The registered manager had generally sent us statutory notifications of events as required. However, there were three instances, relating to medicines, where no notification had been sent. We discussed each case with the registered manager and explained the criteria for notifying us of these particular incidents and of any similar events in the future. We drew her attention to the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The registered manager understood the requirements of this Regulation, but had not realised that these three specific events need to be notified to the Commission. We felt assured the registered manager took on board our guidance and would amend her practice in the future. We asked the registered manager to complete the required notifications retrospectively.

High quality care was delivered; people and their relatives were complimentary about Caer Gwent. One relative said, "It's beautifully run, I can't fault them". Another relative commented, "[Named family member] is very hard to please and would notice anything that's wrong. The manager is everywhere around the building and you can tell that there's no resentment with staff and the atmosphere is good". A third relative told us, "We were at a very low ebb when we came to visit here. We'd been to so many other places, but [named receptionist] was like a breath of fresh air from the minute we walked in, she was exactly what we needed". A fourth relative said, "I feel [named family member] has a much longer life here. I'm sure it's extended her life as the care is so good". People generally said they were happy to recommend the home and had no complaints. However, one person and their visitor expressed concern about another resident at the home and that this person continually called out very loudly that she needed help and wanted to go home. This was proving quite distressing to listen to on a continual basis. The visitor said, "Sometimes it goes on for so long that I go into her to try and calm her as it's so loud. Sometimes it can be so loud that we can't even talk to each other. It really is very upsetting both for that lady and for us having to listen to it". We discussed this concern with the registered manager who was aware of the situation. She told us that she was reviewing this person's care needs to ascertain whether it might prove more beneficial for them to be moved to a different care setting that could provide a higher level of support.

Systems were in place to monitor and measure the quality of the service. Audits were completed in relation to night-time observations, environment, staffing, administration of medicines, cleanliness and infection control, care plan reviews and any improvement actions were recorded. For example, one action identified by the provider stated, 'To ensure care plans are written for new residents and reviews completed consistently'. Accidents and incidents were analysed for any emerging patterns or trends. The registered manager said, "We always look at ways to change and things to improve. Nothing's ever perfect and we strive to do better". A registered nurse commented, "I'm very confident and I learn a lot every day, especially interacting with residents and families. It's a good feeling for example, when a resident is poorly, we give them their medication and involve them in activities. Then we see them getting better".