Hart Care Limited

Hart Care Nursing & Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 3 and 4 May 2016. The first day of our visit was unannounced Our second visit was announced so that arrangements could be made for us to spend time with the provider and acting manager.

Hart Care Nursing and Residential home is registered to provide nursing and personal care for up to 54 people. Most people using the service have multiple health care needs. There were 43 people living at the home on the first day of our inspection; 26 people had nursing care needs.

At the last inspection on February 2015, four breaches of regulation were found. These were because:

- People who use services were not protected against the risks associated with unsafe recruitment processes.
- People who use services were not protected against the risks associated with a poorly managed complaints system.
- People who use services were not protected against the risks associated with a poor quality assurance system.
- People who use services were not protected against the risks associated with poor supervision and appraisal systems.

The provider wrote to us with an action plan to say what they would do to meet the breaches of regulation by July 2015. At this inspection, we found they had followed their action plan and met the legal requirements.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 resigned their position as registered manager at the home. They had applied to CQC to remove their registration. They continued to work at the home as a registered nurse for two days a week. The provider was actively recruiting a new registered manager at the time of our visit. In order to ensure the safe running of the service they had employed an acting manager for two days a week, supported by a deputy manager to keep people safe. The provider also visited the home on alternate weeks to monitor the service and support the staff.

There were adequate staffing levels to meet people's needs. Improvements had been made to the scheduling of staff on duty. People felt there were adequate staff levels but said sometimes staff response times to bells was slow. The acting manager was taking action to monitor the response times to people's call bells.

People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. Staff had received training and had developed skills and knowledge to meet people's needs. Staff relationships with people were caring and supportive. They delivered care that was kind and compassionate.

Measures to manage risk were as least restrictive as possible to protect people's freedom. Medicines were safely managed and procedures were in place to ensure people received their medicines as prescribed. The acting manager was taking action to address any concerns highlighted.

Care plans were personalised and recognised people's health, social and psychological needs. People's views and suggestions were taken into account to improve the service. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments had been completed and best interest decisions made in line with the MCA. Improvements were being made to the provider's computer system to ensure staff were aware of people's legal positions and best interest decisions were recorded.

People were supported to eat and drink enough and maintain a balanced diet. People were positive about the food at the service.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. The acting manager had identified gaps in some of the systems and had put in place an action plan. Where there were concerns or complaints, these were investigated by the provider and action taken. In addition, the premises and equipment were managed to keep people safe.

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.

Staff knew how to recognise signs of abuse and how to report suspected abuse.

There were sufficient staff on duty to meet people's needs.

Appropriate risks to people were identified and reduced as much as possible.

People were protected by a safe recruitment process which ensured only suitable staff were employed.

Accidents and incidents were monitored and any trends identified.

Is the service effective?

Good

The service was effective.

Staff asked for consent before they carried out any personal care. The Mental Capacity Act (2005) was followed. Improvements were being made to the provider's computer system to ensure staff were aware of people's legal positions and best interest decisions were recorded.

Staff received regular training, supervision and appraisals.

Advice and guidance was sought from relevant professionals to meet people's healthcare needs.

People enjoyed a varied and nutritious diet.

Is the service caring?

Good

The service was caring.

Staff were caring and kind. They respected people and treated them as individuals and included them in decision making.

Staff recognised the importance of maintaining family contact.

Visitors and friends were welcomed.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed. Care plans were developed to meet people's needs. Staff were able to record on the provider's computer system checks and support given.

People had been involved in planning their care. Care records were written in a personalised way.

There was an effective complaints procedure in place. People knew how to make a complaint and they had opportunities to offer feedback about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager had resigned. The provider had put in place an acting manager while recruiting a new registered manager.

The acting manager had recognised systems were not effective and was putting in place more robust quality monitoring systems to improve the service.

The provider was accessible for people and staff to speak with.

Hart Care Nursing & Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 4 May 2016 and was unannounced. The first day of our visit was unannounced. Our second visit was announced so that arrangements could be made for us to spend time with the provider and acting manager. The inspection team consisted of two inspectors.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met and observed the majority of the people who lived at the service and received feedback from nine people who were able to tell us about their experiences. We also spoke with three healthcare professionals and an external training assessor to ask their views about the service.

We spoke to 15 staff, including a registered nurse, senior care workers, and care workers, catering staff, a maintenance person, training officer and the administrator. We also spoke with the registered manager, acting manager and the provider.

We reviewed information about people's care and how the service was managed. These included four people's care records on the provider's computer system and five people's medicine records, along with

other records relating to the management of the service. These included staff training, support and employment records, quality assurance audits and minutes of team meetings. We looked at a random sample of call bell records to assess the timeliness of staff responses. We also contacted health and social care professionals and commissioners of the service for their views. We received a response from one health professional.

Good

Is the service safe?

Our findings

At our last inspection, there was one breach of regulation. This related to unsafe recruitment processes. At this inspection improvements had been made and this regulation was now met.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed. Following our last inspection the provider had ensured all new staff had police and disclosure and barring checks (DBS), appropriate references were obtained and employment gaps were explored. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. A new staff member confirmed they had not been able to start work at the home until they had a DBS and two satisfactory references in place. The provider assured us checks would also be completed on existing staff to ensure they were satisfied they were of good character.

People and visitors said they felt the service was safe. One person said, "We are very well looked after."; "You just have to ring the bell and they (the staff) come"; "They can be relied on" and "It's pretty good here on the whole. We have our problems" and "yes ever so."

Medicines for people with a nursing need were administered by nurses and senior care workers administered medicines for people without a nursing need. The nurses had their competencies assessed by the registered manager or the deputy manager. Senior care workers had their competency assessed by the nurses. One senior care worker said, "I did a medicine course and three lots of training with (deputy manager) before being signed off." Nurses and senior care workers were seen administering medicines in a safe way. They had a good understanding of the medicines they were giving out.

Where people had medicines prescribed as needed, (known as PRN), protocols were not in place about when and how they should be used. The acting manager had recognised this and had added it to their action plan to put in place.

There was a system in place to monitor the receipt and disposal of people's medicines. There was a system to monitor daily the temperature of the medicine fridge and that it was at the recommended temperature. There were gaps in these recordings which we discussed with the acting manager who confirmed they would take action. However on the day of our visit there were no medicines stored in the medicine fridge. Medicines at the service were locked away in accordance with the relevant legislation. Medicine administration records were accurately completed and any signature gaps had been identified by the nurses and action had been taken to ensure people had received their medicines. A senior care worker said they had recently had a pharmacy visit; however they could not find the copy of the report. The registered manager had as a result of the pharmacy review made a notice to inform staff areas where they needed to improve. This notice only identified small concerns which would reflect the pharmacy review had not raised any significant concerns. People said they were given their medication and creams were applied as necessary and they were happy with their treatment. People said they were happy with how they received their medicines. Their comments included, "They bring my tablets now after breakfast which is better" and "I get pain relief when I need it."

The provider said in their PIR that "The medications will be computerised to assist with administration, the reduction of drug errors, stock control, auditing and disposal. It is designed to make medication the administration process safer and methodical. There will be training for all medication trained staff on the system put in place prior to use." The provider had scheduled a training day with the computer system designer to have a clear understanding of how the system would work before it was put into place. Care workers were already using the provider's computer system to record when they had administered people's prescribed topical creams.

Our observations and discussions with people and their relatives showed there were sufficient numbers of staff on duty to keep people safe and meet their needs. Staff were seen to be busy but appeared to have time to meet people's individual needs. During our visits call bells were answered in a timely way. However there was no system to undertake formal audits of the call bells to ensure this was always the case. People, when asked, had a mixed response regarding the staff response times to their bells. Comments included, "They are supposed to answer the bell in six minutes but can take a lot longer than that"; "Sometimes they answer the bells quickly but not always" and "Call bells can take a long time to be answered. There is not enough staff, they work so hard."

We discussed these concerns with the provider. They said there were two seniors on duty each day, one to administer people's medicines and one to supervise the care workers and to answer call bells. We looked at a random hour of call bells responses and found all of the call bells during that hour had been responded to within eight minutes. The acting manager added regular call bell audits to their action plan in order to monitor call bell responses.

Staff said they felt there were adequate staff to meet people's needs when a full complement of staff were on duty as scheduled. Comments included, "Today is a good day, sometimes it is the calibre of staff not the quality, sometimes we have lots of (supporting people with their meals) which can make it difficult. We could have help with these"; "When fully staffed there are enough" and "some rooms are vacant so there are enough staff."

The staff schedule showed during the day there was a nurse on duty, usually with two senior care workers and six or seven care workers. At night there was a nurse and four care workers. They were supported by a hospitality worker whose duties included each morning to ensure people had their breakfast and had beverages. There was also a maintenance person, housekeeping, catering, administration and laundry staff who also interacted with people while undertaking their roles.

Staff were positive about improvements which had been made to ensure there were adequate staff on duty. The provider had reallocated the responsibility of completing the staff schedule to a senior member of staff. Staff said there had been improvements in the staff allocation since they had taken on the role. Staff comments included, "We could do with more staff to cover immediate sickness. It is better since (senior) has been doing the rota, most days are fully covered... everything is going well."

Staff undertook additional duties and if required the provider used the services of local care agencies to cover gaps. The provider said the use of agency care workers at the service had decreased considerably. They went on to say, "We do use agency but it is the last option. We have a really good team of staff who usually cover." One care worker commented, "Sometimes ups and downs, if someone is ill there can be problems. They call the agency… not so bad as we have loads of staff now. There is a good number if we have more residents we have more." Another commented, "We try not to use agency as it is better to have staff people know."

Staff were aware of their responsibilities with regard to protecting people from possible abuse or harm. They had received training about safeguarding people and were able to describe the types of abuse people may be exposed to. This included the maintenance person who had previously been identified as not undertaking safeguarding training. Staff were able to explain the reporting process for safeguarding concerns. For example one care worker said, "I wouldn't let it go as I would be as bad as the abuser." They were confident action would be taken by the provider about any concerns raised. They also knew they could report concerns to other organisations outside the service if necessary. The provider was aware of their responsibilities and had in the past made appropriate safeguarding alerts to the local authority team. However one safeguarding issue had not been acted upon quickly. This was because the provider and acting manager had not been made aware quickly of the concern. As soon as they were aware they took action to make people safe. As a result of this the acting manager put in place a protocol to guide staff what they should do in the event of a concern and who they should contact.

People were protected because risks for each person were identified and managed. Computerised care records contained risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin integrity, nutrition and manual handling. Staff were proactive in reducing risks by anticipating people's needs and intervening when they saw any potential risks. People assessed as at risk of developing pressure sores had equipment in place to protect them. This included pressure relieving cushions on their chairs. Pain assessments were undertaken and action taken to contact the persons GP and analgesia prescribed.

The environment was safe and secure for people who used the service and staff. A full time designated maintenance person over saw the maintenance at the service. They undertook regular checks of the service which included, checking water temperatures, bed rails, drains and portable appliance testing (PAT). They also undertook checks of rooms before new people came in to ensure the call bell, bed and television were working. They said they undertook PAT testing of people's portable appliances when they came into the home. Their comments included, "I do as soon as a new person's stuff comes in."

External contractors undertook regular servicing and testing of moving and handling equipment, gas, electrical and lift maintenance. Fire checks and drills were carried out and regular testing of fire and electrical equipment. During our visit, an unscheduled fire alarm sounded. Staff all attended. Delegated staff undertook a check of the highlighted fire zone while others ensured everyone in the building was accounted for. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person.

The home was clean throughout without any odours present and had a pleasant homely atmosphere. Some bathrooms were cluttered with pieces of equipment. The provider said these rooms were not being used as bathrooms. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. Staff had access to hand washing facilities and used gloves and aprons appropriately. Soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance.

Emergency systems were in place to protect people. There were individual personal evacuation plans which took account of people's abilities, the assistance they required, room location and equipment needed. These were held inside the fire book accessible to the fire services in the event of a fire emergency. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely. The acting manager had made an action in their action plan to reassess everyone at the service to ensure they were all accurate. Accidents and incidents were reported in accordance with the organisation's policies and procedures. They were reviewed to identify ways to reduce

risks as much as possible and relevant health professionals and relatives were informed.

Good

Is the service effective?

Our findings

At our last inspection, there was one breach of regulation. This related to staff not being supported in their role with supervisions or appraisals. At this inspection improvements had been made and this regulation was now met.

People received care and support from staff that received training and support on how to undertake their role safely and effectively. The provider had recruited a training officer who oversaw the staff training at the service. They said mandatory training staff completed included, manual handling, fire and safeguarding vulnerable adults. Where a staff member had not completed the providers mandatory training the provider had made the decision they could not undertake duties until completed to keep people safe. Staff were also completing long distance learning courses which included, equality and diversity, understanding autism, dignity and safeguarding in adult care and mental health awareness. The training officer said they supported staff to undertake higher national qualifications in health and social care. They confirmed most staff had been signed up with external training providers. Staff were positive about the training they received. One care worker commented, "It is good, (training officer) is a really good help. Training has improved since she has been doing it." Another said, "I am also doing end of life training. I really enjoyed the training especially mental health awareness, dementia and learning disabilities with young children and adults work book."

During our visit two care workers had meetings with their training assessors. One said they were enjoying their training and intended to undertake the next level. Designated staff were undertaking additional training in infection control, manual handling and nutrition in order to be the leads at the service.

The nurses at the service undertook additional training to ensure they had the knowledge and competence to undertake their role. This included verification of death training, catheter care, syringe driver training (a small, portable pump that can be used to give you a continuous dose of painkillers and other medicines through a syringe) and first aid.

Checks were made by the registered manager to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK. The provider said they would be extending the training officers role to oversee the nurses training and complete regular NMC registration checks.

Induction training consisted of a period of 'shadowing' experienced staff to help new staff get to know the people using the service. New care workers who had no care qualifications, undertook the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice. One new care worker said, "I did shadow shifts. I wasn't allowed to use the hoist until I had done the training." Another care worker said, "It was a lengthy induction. I did everything, safeguarding, DoLS (deprivation of liberty safeguards), it took me weeks to cover it. It was everything you would need for a nursing home. It was good also to have refresher training."

Staff confirmed they received supervision on a regular basis. They said they found the supervisions really useful and were positive about the acting manager. Comments included, "(Acting manager) is really supportive and approachable" and "I did one a couple of weeks ago it was an hour and a half, we went through everything, it was very good." There was a programme of appraisals scheduled to be undertaken.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People 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 Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards and we found the home was meeting these requirements.

People confirmed they were always asked for their consent before care and support was provided. Staff involved people in decisions about the care they received. Staff had considered people's capacity to make particular decisions and knew what they needed to do to ensure decisions were made in people's best interests. Professionals and relatives had been involved in the decision making process where appropriate. The service had included an independent mental capacity advocate (IMCA) for a decision around resuscitation for person who had no relatives that could be consulted. The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions. There was not a clear system to demonstrate that the service had assured themselves of people's relative's rights regarding their power of attorneys and the authorities they had. The management team were aware of the different types of powers of attorneys but were unable to tell us which one nominated people had. The acting manager said they would add this to their computer system to ensure it was clear.

Staff had received training about the MCA and they demonstrated an understanding of people's right to make their own decisions. When asked about their understanding of the MCA. Comments included, "Helps to be aware of restrictions and the rights of our clients to make sure what we are doing in our client's best interest"; "Understanding what they are going through, why they act as they do and how to interact with them"; "Making decisions for residents who don't have capacity to protect themselves and "Respect dignity and decisions."

People had access to healthcare services for on-going healthcare support. They were seen regularly by their local GP, and had regular health appointments such as with the dentist, optician, and chiropodist. People's medical history and health needs were recorded on the provider's computer system. All relevant staff had a unique identification access code which ensured they could access the information to be aware of any concerns. The care records contained the contact details of GPs and other health care professionals for staff to contact if there were concerns about a person's health. Staff worked with health professionals such as the community nurses, occupational therapists and physiotherapists. Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately. For example, staff had identified a sore place develop on a person's skin. The staff consulted the community nurses and undertook their guidance of alternate movement and barrier cream. A visiting district nurse said, "Staff are very vigilant and contact us, however small, which is good. Everyone appears well looked after and the staff are lovely. I do not think there is a problem with staffing. No concerns to report." A visiting GP said, "Very good on the whole. No problems with people being unsafe…they call promptly visit …no problems being called too late. People are clearly well looked after. Relatives on the whole are very complimentary about the care here."

People were supported to eat and drink enough and maintain a balanced diet. The service had a four week rotating menu. The cook said when a new person came into the home the staff completed a nutrition form about their likes, dislikes and meal requirements which was given to the kitchen. There was also a white board in the kitchen where staff recorded people's changing wishes and needs so all staff would be aware of changes.

We observed a lunchtime meal in the newly decorated dining room on both days of our visit. There was a pleasant atmosphere and people were interacting sociably with other people using the service. People had been asked the previous day for their meal choices and were having meals as they had chosen and were positive about the food. Comments included, "The food is very good. There is always a choice. Gammon today, lovely." The food was nice, I like cottage pie. They do come and ask what you want": "You can have bacon and eggs for breakfast, every day if you wish.": "There is always an alternative to eat" and "We get fed too well. Cream cakes at times."

Care workers wore blue aprons at meal times to cover their uniforms in order to ensure good food hygiene. They were very attentive to people's needs, ensuring they had drinks. Three people were being supported with their meals. Care workers were sat with these people and supported them without rushing and explained and engaged in conversation.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. We spent time talking with people and observing the interactions between them and staff. Staff were kind, friendly and caring towards people. People were seen positively interacting with staff, chatting, laughing and singing. People said they were happy at the home. Comments included, "On the whole, things are pretty good. The staff are dependable"; "They (the staff) are very good" and "The staff are lovely, kind and polite."

Staff said they felt the care was good at the service. Comments included, "The attitude of the staff is good and compassionate with looking after the clients"; "I know the staff, some are not perfect but when it comes to caring they are always there for them (people). I know how they are taken care of, I would be happy for my mum to be taken care of here" and "We are not 100% but are doing our best to give good quality of care." One care worker said they had a bad experience with the care of their relatives at another care home. They said "I wish they had been able to come here, we care, and they are not just shut in a room, if they want a cup of tea with a biscuit and a chat that's what they get. The quality of care is brilliant, a lovely home one of the best I have worked in."

Staff treated people with dignity and respect when helping them with daily living tasks. Staff said they maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering and gained consent before providing care. Comments included, "I make sure the door is closed and the curtains. If someone knocks on the door. I say that we are doing personal care. If they (person) requests family stay we ensure they are covered up as much as possible"; "I treat as you would like to be treated. I adopt them all, give them a bath or shower and make sure they are covered up. Don't talk down to them (people)." One person said, "The girls are very good they don't gossip. If I ask about someone they say I don't know." However we did see one example where staff had not pulled the curtains on the person's door when they were being seen by a health professional.

Staff treated people with kindness and compassion in everything they did. Throughout our visits staff were smiling and respectful in their manner. They greeted people with affection and by their preferred name and people responded positively. The atmosphere at the home was calm. During lunch a staff member supported a person eating their lunch in the dining room. They were discreet and not rushed in their approach and retained eye contact with the person throughout to give them reassurance.

Staff involved people in their care and supported them to make daily choices. For example, people chose the activities they liked to take part in and the clothes they wore. Staff described ways in which they tried to encourage people's independence such as dressing themselves with minimum support. Staff said they knew people's preferred routines, such as who liked to get up early, who enjoyed a hot drink at bedtime and a late night chat. They ensured people were given a choice of where they wished to spend their time. When people arrived at the home they were asked to formally consent to having care at Hart Care and permission to share information with relevant agencies, receive medication and their preferred gender of carer.

People's relatives and friends were able to visit without being unnecessarily restricted. People said their

visitors were made to feel welcome when they visited the home. People's rooms were personalised with their personal possessions, photographs and furniture. One person who had their own landline telephone in their room said, "I own the furniture and pictures the (maintenance person) will do anything I ask, he does it quite nice."

People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented, including the person's views about resuscitation in the event of unexpected illness or collapse. One person was receiving end of life care at the home at the time of our visit. The staff worked closely with people's families and health professionals to ensure they were informed. They had worked with people's GP's to ensure medicines had been prescribed to be used to help people at the end of their life and remain comfortable. Specific end of life care plans had been put into place to guide staff how to keep the people comfortable. This included, to offer diet and fluids as the person would take, two hourly checks and repositioning, monitor pain levels and to liaise with relatives. One care worker said, "If someone is dying we let the family know we are here if they need us. We pop our head around the door." Staff were undertaking training in, death dying and bereavement in order to add to their knowledge of how to support people at the end of their lives.

Good

Is the service responsive?

Our findings

At our last inspection, there was one breach of regulation. This related to complaints being poorly managed. At this inspection improvements had been made and this regulation was now met.

The provider had taken on responsibility for dealing with any concerns or complaints. The administrator worked with the provider. They said, "I deal with complaints to a degree, I work closely with (provider) and collate information." Complaints received since our last inspection had been addressed in line with the provider's policy. However one complaint had not been resolved to the complainant's satisfaction. This was after the provider had met with the complainant, undertaken an investigation and responded their findings in detail.

People and their relatives knew how to share their experiences and raise a concern or complaint. People were happy they could raise a concern if they needed to and were confident the provider would listen and take action if required. One person commented, "If I was concerned, I would speak to the nurse, (administrator) or (provider). I have not needed to make a complaint though."

There was a complaints procedure displayed in the main entrance at the service. The procedure included information about the external agencies people could contact if they were not satisfied with the response from the service.

The service was responsive to people's needs because people's care and support was well planned and delivered in a way the person wished. Wherever possible a pre admission assessment of needs was completed prior to the person coming to the service. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. This information was used to develop comprehensive care plans. Care plans were recorded on the providers computerised system. Throughout the home there were nine computer tablets and two desktop computers where staff could access people's information using a unique identification access code. Care workers could record tasks completed and relevant information about people. For example checks undertaken, care and support given and diet and fluid intakes.

Care files included personal information and identified the relevant people involved in people's care, such as their GP, optician and chiropodist. Care plans gave information about people's health and social care needs and showed that staff had involved other health and social care professionals when necessary. When necessary, referrals were made to the Speech and Language Therapy (SALT). Where recommendations had been made to reduce the risks to people, these had been incorporated within the care plans. A visiting speech and language therapist said they had timely referrals and were happy staff acted upon their advice. In the kitchen staff had information about people's identified special diets, whether diabetic or fortified and the required consistency of food, for example whether fork mashable or pureed.

Relevant assessments were completed and up to date. However not everyone's care plans had been reviewed in a timely way. The acting manager was aware that one person's care plans had not been

reviewed to ensure they were accurate and reflected the care the person received. By the end of the second day of our visit this person care plans had been reviewed. The acting manager had put on their action plan that checks on all care plans were up to date and reviewed with people and their families and friends as appropriate.

Risk assessments included an assessment of nutritional needs, mobility, falls and skin integrity. Nurses and senior care workers completed monthly reviews of people's risk assessments and care plan reviews of designated individual people's needs. People and their families were given the opportunity to be involved in reviewing their care plans. One person said, "We each have a care plan and it gets stuck to."

When people were unwell at the home, staff implemented an intensive care document which staff completed each time they undertook a check and performed tasks for people. These included, repositioning them, oral care, continence support, fluids and checking on the persons skin integrity. Staff were undertaking the checks as required but sometimes recording them on this document and other times in the daily notes. The provider and registered manager said they were working with staff and the writer of the computer program to make this clearer.

People were supported to take part in social activities. The care workers were designated to undertake activities each afternoon as part of their role. People had the opportunity to join in group activities. However there was no clear system to ensure all people had the opportunity to partake in regular meaningful activities. There were also external entertainers who visited the home to entertain people. People's comments included, "The staff are very good at helping people to play bingo"; "We have lovely music afternoons"; "We have a really good work out on a Monday. Exercises, ball games. The activity people keep us occupied" and "I spend all of my time in my room, which is quite nice, I am never lonely."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, there was one breach of regulation. This related to poor quality monitoring systems. At this inspection improvements had been made and this regulation was now met.

The registered manager had submitted their resignation to the provider and was working at the service as a nurse two days a week. The registered manager had also submitted their application to deregister with the Care Quality Commission (CQC). The provider had taken steps to ensure people's safety by appointing an acting manager while looking to recruit a new registered manager. The acting manager worked at the home two days a week supported by the administration staff, nurses and team leaders. Staff described the acting manager as someone they had confidence in and could contact if they had any concerns.

The provider visited the home for a couple of days on alternate weeks. They were also in daily contact with the administration staff at the home to ensure the service was running safely. The provider said, "Our philosophy is to run the home as a five star rating. With individual personal care." The provider completed a monthly monitoring form when they visited which included an inspection of the premises, records, complaints, activities, quality assurance and recruitment. They gave an example of where a carpet was not acceptable so had a new one put down. They had recorded on the March 2016 monitoring form about having no manager and the implications. They identified that the majority of care plans had been completed with a few to finish. They said as part of their visits they spoke with people to ask their views. However they did not always record these conversations.

The acting manager and the provider could access the services computer system remotely. This meant they could monitor care records and look at messages while not at the home. People and staff were very positive about the provider and said they spoke with them regularly. Comments included, "When (provider) is here he always speaks to each one of us"; "(Provider) is really helpful. He will ask if there are any problems. I can discuss things with him… he is open and asks if there is anything he can do" and "Good as gold, I can go to him… not at all scary."

The acting manager had recognised systems were not effective and had produced an action plan to improve the effectiveness of the service. For example, audits, supervisions and staff meetings. We were given a copy of the action plan which set out the improvements being put into place and the expected time scales to be implemented.

Staff had a clear understanding of their roles and responsibilities. The nurses on duty were responsible for people receiving nursing care. They administered their medicines, completed their care reviews and undertook any nursing requirements. Senior care workers were responsible for people who did not have a nursing need. A nurse said they supported the senior care workers with more specialist medicines and were positive about the role of the senior care workers. They said, "The seniors are excellent, the standard of care is better and everyone's needs are met." Another nurse felt at times it would be beneficial to have a second nurse on duty as a lot of responsibility for all of the people at the service fell on the nurse on duty. The acting manager said they had increased the amount of senior care workers by two making there six. They said they

were trying to empower senior care worker to take on more responsibilities. One senior care worker said, "I am doing medicines, dealing with staff problems. I do records for everyone. If a GP comes in I document what they said."

People were asked to share their views about the service through the use of satisfaction surveys and regular visits by the provider. In August 2015 people were asked to complete a questionnaire about the service provided. This included how they felt about the food, their room colour, did staff understand their needs and whether they had a choice of when they wanted to have a bath. The results of this survey were mainly positive and where issues had been raised the provider had taken action to resolve people's concerns. For example they had addressed a persons concern about a meal being cold. However they had not collated the results and shared them with people using the service and staff. The acting manager said they would be carrying out another survey in May 2016 and the results would be collated and shared. They gave an estimated time scale that they would be collated by the end of July 2016. People also received monthly newsletters to let them know what was happening at the service and any special events.

Staff meetings were held regularly and minutes of the meetings showed a variety of topics were discussed and staff were able to share suggestions and voice their views. Staff said meetings were an opportunity to come together and share ideas. The acting manager had also had meetings with seniors care workers regarding care plan reviews and supervisions.

Staff had a staff handover meeting at the changeover of each shift where key information about each person's care was shared. This meant staff were kept up to date about people's changing needs and risks.

The provider had displayed the previous Care Quality Commission (CQC) inspection report of the service in the main entrance. However, they had not displayed the rating on the services website. We discussed this with the provider and they said they would address this.

The provider was meeting their legal obligations. They notified the CQC as required with the exception of a safeguarding notification which was not submitted in a timely way. They provided additional information promptly when requested and working in line with their registration. The provider also kept CQC informed about how they were managing the service while they recruited a new registered manager.