Complete Care Homes Limited

Rambla Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 7 and 11 April 2016 and was unannounced. The provider of this service changed. This is the first inspection of the service with the new provider. This has been a change in provider name only in order to rationalise the registration across the provider group. The professional relationships remain with the same individuals as under the previous registration.

Rambla Nursing Home provides personal care for up to 30 older people who may have nursing needs. The service is also registered to care for younger adults, people who are living with dementia and people whose needs are predominantly associated with physical disability. On the two days of the inspection there were 30 people living in the home. The home is located in the town of Scarborough.

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

Medicines were generally safely handled; however, we noted one aspect of medicines handling which was unsafe. This was a breach of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

Risks were generally well assessed to protect people, however falls risk assessments did not always clearly outline the current risk to people. Risk assessment guidelines were occasionally not acted upon to protect people. We made a recommendation about this.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the home. The home had sufficient suitably recruited and trained staff to care for people safely. The environment of the home was safe for people and safety checks were regularly carried out. People were protected by the infection control procedures in the home.

Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They understood that people should be consulted about their care and the principles of the MCA and DoLs. People were protected around their mental capacity.

People's nutrition and hydration needs were met. People enjoyed the meals and they were of a good quality. Risks were generally well assessed and specialist advice was usually followed. However, we made a recommendation about the way in which risk was assessed in relation to monitoring weight and a further recommendation about one instance of following specialist advice in relation to eating and drinking.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with dignity and respect. Staff had knowledge and understanding of people's needs and

worked together well as a team. Care plans provided detailed information about people's individual needs and preferences. Records and observations provided evidence that people were treated in a way which encouraged them to feel valued and cared about.

People were supported to engage in daily activities they enjoyed, which were in line with their preferences and interests. Staff were responsive to people's wishes and understood people's personal histories and social networks so that they could support them in the way they preferred. Care plans were kept up to date when needs changed, and people were encouraged to take part in their reviews and to give their views which were acted upon.

People told us their complaints were responded to and the results of complaint investigations were clearly recorded. Most people we spoke with told us that if they had concerns they were always addressed directly with the registered manager who responded quickly and with courtesy.

The service had an effective quality assurance system in place. Rambla Nursing Home was well managed, and staff were well supported in their role. The registered manager had a clear understanding of their role and they consulted appropriately with people who lived at the service, people who mattered to them, staff and health care professionals, in order to identify required improvements and put these in place. However, records around good governance were not always clear or complete. This was a breach of Regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Though people were generally protected by the way the service handled medicines, this was not always the case. Although most risk plans protected people from current risks to their wellbeing this was not consistent.

People were protected from the risks of acquiring infection because the service had good infection control policies and procedure and staff acted on these.

People were protected by having sufficient staff who were safely recruited and had the skills and experience to offer appropriate care.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People told us that they were well cared for and that staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide good care.

The service met people's health care needs, including their needs in relation to food and drink. However the service was not consistently assessing the risk in relation to monitoring weight and pressure care risk.

Specialist advice was generally followed, however for one person we found this had not been followed accurately.

People were protected in relation to their mental capacity and they were asked for their consent to care.

Is the service caring?

Good

The service was caring.

Staff had developed respectful and caring relationships with

people. Staff involved people in all decisions.

We observed that staff had respect for people's privacy and dignity.

Staff supported people to be as independent as possible.

People received compassionate and appropriate care when they reached the end of their lives

Is the service responsive?

Good

The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests which supported staff to offer person centred care.

People were supported to live their lives in the way they chose.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Records did not always support the service to assess, monitor and improve the quality and safety of the service.

There was a registered manager in place. Leadership was visible and there was a quality assurance system in place so that the registered manager could monitor the service and plan improvements.

Communication between management and staff was regular and informative.

The culture was supportive of people who lived at the home and of staff. People were consulted about their views and their wishes were acted upon.

Rambla Nursing 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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 11 April 2016 and was carried out by two adult social care inspectors and a specialist advisor. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. We received a Provider Information Return (PIR) from the service. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used the information on the completed PIR to support our judgements and also gathered information we required during the inspection visit.

Before the inspection visit we spoke with one health and social care professional. During the inspection visit we spoke with seven people who lived at the home, three visitors, five members of staff and the registered manager. After the inspection visit we spoke with two health professionals.

We looked at all areas of the home, including people's bedrooms, where people were able to give their permission. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at four care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for three members of staff. We also observed the lunchtime experience and interactions between staff and people living at the home.

Requires Improvement

Is the service safe?

Our findings

We looked at the way medicines were handled in the service. We noted that the medicines cupboards were not sufficiently clean or free from non- medicinal clutter. This introduced an infection control risk and the potential for medicine error.

The registered manager said that they regularly checked medicines however such audits were not recorded. This meant that there was insufficient evidence of a clear audit trail around medicine handling. This could mean that errors or trends may not be recognised or actioned effectively. We noted a number of gaps in recording which meant in these cases that the registered manager could not be sure that people had received their medicines as prescribed.

We received information that medicines had been placed into a pot and left in a person's room for trained staff to administer at a later time. The registered manager agreed that this practice had occurred on more than one occasion. This is unsafe practice and placed people at risk of medicine error.

Failing to ensure that people are protected through safe medicines handling is a breach of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, despite these shortfalls, medicines to be administered were stored safely and those medicines awaiting return were stored separately and accurately recorded. The home operated a monitored dosage system (MDS) for medicines. This is a storage device designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. We found that medicines were generally managed safely through this system.

An external pharmacy audit had recently taken place and the required actions had been implemented. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, (CDs) which are medicines that require extra checks and special storage arrangements because of their potential for misuse. This meant that people were protected around the management of CDs.

Nurses had received specific training in care for people when they were reaching the end of their lives, and in the administration of pain relief via syringe driver. This meant that people had access to appropriate care and pain relief when they needed it.

Risk assessments were in place for each person who lived at the home. These covered such areas as falls, moving and handling, the use of bed rails, pressure care, nutrition and fluids. Most risk assessments were updated to reflect changing needs. However, the way risk assessments were used did not always lead to referrals to health care professionals as indicated in the home's own guidance. For example, falls risk assessments were carried out when a person first arrived at the service. These would sometimes show that a person had a level three risk or above, which would indicate a referral to the falls team. However, no such referrals had been made. A supporting narrative about whether or not to refer to the falls team and the rational for this was also absent. In these cases it was unclear why the person had or had not been referred.

The registered manager told us that the risk assessments were based on the place where the person had been living prior to coming to live at Rambla and so were not a true indication of the level of risk in the care home environment. However, risk assessments had not been updated to reflect the change in risk once a person had settled into living at Rambla and so were not current or helpful in planning the delivery of safe care.

We have made a recommendation about risk assessment at the end of this key question.

We looked at a number of risk management plans around moving and handling. We found that plans were written with regard to people's fluctuating needs in relation to this. For example, one person might require two staff to move them at times, but at other's it would be safe to support them to move with one member of staff. However, one plan stated that two members of staff were required at all times, and we were informed that on at least one occasion this move had been carried out by one member of staff alone. The registered manager explained how this situation had been dealt with to protect people from further exposure to risk.

However, all the people we spoke with on the day of inspection told us they felt safe. They made positive comments including, "I feel safe and looked after" and, "I was falling a lot at home and know I am much safer in here." Another person told us, "I know that it is safer for me in here because if I was at home it would be a risk to me" and, "I use a walker and am much more confident now, I haven't fallen since I came here."

Another person we spoke with told us, "I feel safe at night time, when I press my buzzer they [care workers] don't delay and they are sympathetic and understanding." One relative told us, "There are always enough staff on duty and the level of care [person's name] needs cannot be provided at home, so we know [person's name] is safe here." We found that people's feedback on the day of inspection about the safety of the service described it as consistently good and that they felt safe.

We saw there were safeguarding policies and procedures in place. Staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the home procedure was in relation to safeguarding.

The registered manager had kept CQC informed about safeguarding incidents which had taken place in the service. Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively.

We asked the registered manager how they decided on staffing levels. They told us this depended on the numbers and dependency levels of the people living at the home at any time. They explained that during the morning shift from 07.30 until 14.30 and for the current occupancy of 30, there was usually the registered manager, a nurse and seven further care staff. From 14:00 until 21:00 there was a nurse and four care staff, and at night there was a nurse with two care staff. Shift start times allowed for a handover so that information of concern could be communicated between staff to protect people's safety. An activities organiser was also employed four days a week who was supported by two volunteer activities assistants. The registered manager told us they considered skill mix and experience when drawing up the rota. We spoke with staff about this and they confirmed that they felt there was a good skill mix on duty and that there were enough staff on each shift to meet people's needs. They told us that most of the time they did not feel rushed. Our observations on the day of inspection confirmed there were sufficient staff to care for people safely.

Accident forms had been completed and each accident was logged on the daily notes. This was useful for reference and to inform health care professionals should a visit be needed.

We looked at the recruitment records for three staff which showed safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) for each member of staff and that two references were obtained before staff began work. The DBS checks assist employers in making safer recruitment decisions by checking that prospective care workers are not barred from working with certain groups of people. This meant that the home had taken steps to reduce the risk of employing unsuitable staff. Nurses had been employed following a check that they were registered with the Nursing and Midwifery Council (NMC) to ensure they had the correct registration to offer safe care.

All areas of the home were accessible by lift. Environmental risk assessments were in place including a fire risk assessment with individual evacuation plans in case of a fire. We saw that entry to the home was controlled and there were keypads on the exit doors for people's safety. Health and safety checks were regularly carried out as part of the quality monitoring system and any required actions were acted upon. There was safe wheelchair access to the garden. One person said "I like to go in the garden in my wheelchair in the good weather, it's beautiful." It was evident that the service kept the garden area safe and well maintained, reducing the risk of injury when people used it. This helped to ensure people were protected from the risk of harm.

In a recent survey sent out to gather views and opinions of the service, people's comments were positive and they wrote that the home was, "always spotless", and "it is so well maintained".

We spoke with one professional who told us, "I see people in their rooms and can see that all the hygiene products needed are there: gloves, aprons etc, and every room has the facilities needed" and, "I see people who are often in bed and the bed linen is of a high quality and always clean and people are well-dressed and cared for."

We observed that staff wore protective aprons at mealtimes which is good practice and in line with infection prevention and control measures. Staff told us that they had received training in the control of infection during their induction and had received regular updates. They correctly described how to minimise the risk of infection. They spoke of the correct use of aprons and gloves and also told us that they washed their hands frequently and always between offering care to people. The service had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. Wall mounted sanitising gels were available on each floor of the home, and people's individual rooms had wall mounted soap dispensers, paper towels and sanitising hand gel in line with current best practice guidelines. The laundry room had a suitable washing machine and dryer. Dirty and clean laundry were kept separate to minimise the risk of cross infection. In a recent survey everyone who had answered the question related to laundry indicated that their clothes and bedding were well laundered.

We recommend that the registered provider consults best practice guidance in assessing and recording people's changing needs in relation to risk.

Requires Improvement

Is the service effective?

Our findings

Most people told us they felt staff had the right skills and knowledge to provide effective care and support. One person said "They all [staff] know how to use my hoist and if anything was wrong I would tell them, but they don't do anything wrong" and "They have their jobs to do and always ask for my consent and have a good attitude to any changes I might want." This demonstrated that staff knew how to use equipment correctly.

However we received a number of comments from a third party prior to our inspection which indicated they were not happy with the meals or the way a person was supported with food and fluids. They also raised a number of concerns about the management of clinical care, including pressure care and moving and handling. These concerns are currently being investigated through the local authority safeguarding team to which there was as yet no conclusion.

The home had links with specialists, for example in diabetic care, nutrition, sight and hearing, pressure care and the speech and language therapy team (SALT). This helped them to offer appropriate and individualised care. We saw that referrals for specialist input had been made promptly in discussion with each person where appropriate. Evidence was available that specialist advice had been incorporated into care plans for staff to follow and for most people this was followed accurately. We noted that for one person the advice was not being followed exactly as written. For example, staff were not always supporting the person to have a clean mouth using sponge sticks after all meals and were not always ensuring that the person was assisted with eating at the correct angle. We have made a recommendation about this at the end of this key question.

When we spoke with a health care professional they confirmed that in their opinion the service was maintaining good hydration and nutrition for people who lived at Rambla and that their clinical practice in this area was good.

Food and fluid monitoring charts were in place to protect people where necessary. These were usually accurately completed with few gaps. We noted that for one person there were occasional gaps. Staff told us that visits had taken place but that they had sometimes forgotten to record them on the chart. This meant it was not always clear when this person had been visited in their room.

We saw that most people were weighed every month and a malnutrition universal screening tool (MUST) was used to determine whether or not they were at risk of malnutrition. However, we noted that when one person could not be weighed the service had not employed another method of estimating weight changes according to MUST guidance, for example by measuring the mid upper arm circumference. Nurses told us that they estimated weight through observation and knowing how a person presented over time. This was not always a reliable method of monitoring those people who were vulnerable to fluctuations in weight and did not follow the MUST guidance. We have made a recommendation about this at the end of this key question. However, although practice could improve in this area, we spoke with a health care professional about this who was able to tell us that in their opinion, this had not led to a detrimental outcome for anyone

living at Rambla.

Care plans contained details of people's clinical care needs for staff to follow. Occasionally care plans had not been updated to remove outdated information, which caused the potential for confusion. However, nurses we spoke with were able to tell us the care which each individual currently needed.

When people told us about the meals, they all made positive comments, such as "The food is wonderful and there is always an alternative" and "I get choices of food and it's really good." One person told us "The chicken pie is lovely, it's my favourite" and another person said "I am used to more spicy foods and the cook has cooked curry and lentil soup a few times." People confirmed that the food was consistently good and spoke positively about the menu and the quality of food provided.

One relative we spoke with told us, "They help [my relative] with eating lunch if family are not here." This was confirmed when we reviewed their care plan and spoke with the person, who said "The care is good and I always have someone with me at mealtimes."

We observed people having a three course lunchtime meal in the dining room. Wheelchairs were safely positioned at tables, and people were asked if they would like to wear a clothes protector whilst eating. Two care workers were supporting people at lunch time and one of them did not leave the dining room throughout the mealtime. This meant that a member of staff was nearby at all times to assist people. The food appeared nutritious, well presented and people were given choices of drinks to have with their meal. Care workers were very attentive to people's needs, supporting them when required and regularly asked them about the dining experience. This meant that staff responded to people's needs regarding support whilst eating and drinking.

Staff told us "There is a hot food option every day and there is always soup available at tea time. Many people like to have a lighter tea if they have had a good lunch and often have soup and a sandwich or a cold option in the evening." This showed that people had choices around their meals.

We spoke with the cook. The cook informed us about individual's needs, e.g. allergies, dietary needs, and people's wishes around specific diets including those in relation to religious needs. These needs were communicated to kitchen staff using a diet sheet for each person which included specialist advice where necessary. This ensured that food and drink was prepared taking individual needs and wishes into consideration.

We consulted with the local authority which had carried out some recent visits to assess the quality and safety of care at the service. They had reported that a small number of people had expressed some level of concern over the way they were supported to move. We spoke with these people again during our inspection. People told us that some staff were occasionally a little quick when moving them, but that generally they were happy and confident with the way they were assisted. Our observations provided evidence that people were moved safely and with care. Evidence gathered during this inspection from records and from speaking with people confirmed that people were supported with their moving and handling safely and effectively.

We looked at staff induction and training records. Each member of staff had an induction to the service. Staff confirmed that they had received induction before they began their mandatory training. During this time they developed a good understanding of each individual's care needs and the philosophy of the home. Staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met. Nursing staff were supported and mentored in their role by the registered manager and the deputy

manager, both of whom were trained to offer such support. The deputy manager told us that another member of nursing staff was being trained to offer mentorship to existing nursing staff and student nurses. The deputy manager told us that nurses also received support to offer appropriate clinical care for people with specialist needs and mentioned working alongside link nurses from the local hospice, tissue viability nurses who supported them around people's pressure care and nurses specialising in continence care.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people's individual needs and how risks were managed.

Staff received a range of training relevant to their role including specially sourced training in areas of care that were specific to the needs of people at the home. This included training in the Mental Capacity Act (2005) and clinical care subjects including palliative care.

Staff told us that they received regular supervision and we saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and to offer the care people needed.

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

People 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 process for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

People's plans of care showed that the principles of the Mental Capacity Act 2005 (MCA) Code of Practice had been used when assessing people's ability to make decisions. The service also had a policy and procedure on the MCA and DoLS to protect people. Staff understood the principles of the MCA and DoLS and were able to tell us about the five main principles, for example that they should always assume a person had capacity rather than not, and they should support people to make their own decisions.

People told us they were regularly asked for their consent to care. We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response. Care records showed that people's consent to care and treatment was sought. Staff recorded how they looked for consent when people were not able to give this verbally, for example, through observing body language or facial expressions.

We recommend that the registered provider consults best practice guidance around implementing the MUST tool to manage the risks associated with receiving sufficient food and drink.

We recommend that the registered provider follows specialist advice so that people's clinical care is appropriate for their needs.

Good

Is the service caring?

Our findings

We asked people if they thought the staff were kind and considerate. Most people agreed that they were. One person told us, "I have good talks with [name of staff member], she is a good lady who treats me like a human being" and "They [care workers] know me as me and we have a really good bond." Another person said "I am happy with everything, they [care workers] treat me as a person and we have many laughs" and "All the staff were very kind to me when I lost a friend and they gave me comfort." However, one person had written that they did not feel that staff were generally kind or considerate, but did describe one member of staff who was.

We spoke with people about their needs relating to equality and diversity and one person told us "My faith is respected and [name of priest] visits me regularly and I take Holy Communion here every two weeks." Another person told us "They [staff] respect my cultural and spiritual needs, so I have no concerns about that." This demonstrated that the service had a proactive approach to respecting people's human rights and diversity.

People had written comments in a survey. One person wrote, "It is very communal and friendly, like a real home. This is mainly due to the cheeriness of the staff." Another person wrote, "Always greeted with a smile and a cheerful hello by staff", and "We enjoy genuine caring support."

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff and there was laughter between them as they chatted. We saw that staff encouraged people to express their views and listened with interest and patience to their responses. Those people who were in discomfort were attended to with kindness. Staff gave the impression that they had plenty of time and spoke with people who were sitting so that they were at eye level with them. They reassured people where this was appropriate. We observed that staff were talking with people about their lives, who and what mattered to them and significant events. Staff interacted well with people who were more withdrawn and adjusted their responses appropriately to each individual.

Staff told us that people who were tired or unwell were consulted at other times when they were at their most comfortable. People who had difficulty communicating were enabled to give their views by staff spending time with them, understanding their body language and/or consulting with those who were close to them. The registered manager had organised for people who needed them, to have communication aids so that they could make an informed decision about options open to them. Staff visited people in their own rooms and chatted to them so that they did not feel too isolated. We noted that staff visited everyone who was being nursed in their rooms in this way.

Some people had Advance Plans in place which were well documented. (Advance Plans record people's preferences when they near the end of their lives). Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place, and where we saw these they were correctly completed and regularly reviewed.

Staff told us about the way people were cared for in their final days. They emphasised the need for close liaison with palliative care professionals, attentive monitoring to ensure people did not suffer pain and how important it was to ensure people had company at their beside. They also spoke about the importance of supporting relatives, the people who lived at the home and each other at that difficult time.

The registered manager told us that they approached the timing of end of life discussions with sensitivity and reviewed them if circumstances changed or if time had elapsed since the last decision. This meant that staff had instructions regarding people's recent wishes and were in a position to offer the care that people preferred at the end of their lives. The service had achieved seven stars in Level 1 Program of Intensive Education & Support for End of Life Care from the local hospice team. This meant that the service was recognised by the hospice for the compassionate for people when they were at the end of their lives.

Good

Is the service responsive?

Our findings

When we spoke to people about their care plans they told us "They have discussed my care plan with me so they know what I need." Another said, "We have meetings about it and I would speak up if I needed to" and "If I was worried about anything I would talk to the staff or the manager." This confirmed that people were involved in developing their care plans.

In a recent survey one person wrote, "The activities are to a high standard and always cater to [my relative's] interests."

People told us that they were confident to raise any concerns or complaints and told us "I would be happy to talk to the staff or the manager if I had a concern or complaint" and "I have never had cause to complain and if anything was wrong I would speak to [registered manager's name]."

One relative told us "My [family member] would talk to staff is they had a complaint, but they are really happy." This confirmed that people felt confident to talk to staff if they had any concerns or wanted make a complaint.

Staff reviewed personal care needs monthly and detailed the needs each person had along with suggestions. For example, one plan instructed staff to encourage the person to make their own decisions, that the person liked to be as independent as possible and to encourage them to be involved with activities.

We found that daily notes included details about each person's frame of mind and how they were feeling when they received care and support. Care plans were reviewed regularly and gave information about a person's preferences and dislikes and detailed family members to contact in an emergency. It was evident when we spoke to people that they felt their care workers knew them well and treated them as individuals.

We spoke with a member of staff who was employed to carry out activities with people. This member of staff carried out an assessment of people's needs in relation to daily routines and activity. They recorded as much information as possible about personal history, spiritual needs, interests and hobbies, likes and dislikes, memories, and significant people and places. This information was used to draw up a care plan which addressed social and recreational needs. This resulted in activities being offered, such as minibus outings, external entertainment being brought into the home, barbeques, a garden party, summer fair, concerts, games such as dominoes and scrabble, bingo, quizzes and painting. Hand eye coordination games were offered such as bean bags and skittles. For those people who were nursed in their rooms, or who did not wish to participate in group activities staff visited them on a one to one basis, read to people, wrote letters and arranged for the musician to visit people in their own rooms and sing to them. Most people told us that staff worked hard to entertain them and that they had plenty of interesting things to do.

The home regularly held meetings to gain people's feedback and also often asked for the views of relatives and other visitors, which were recorded. We spoke with a person who had been involved in a resident

meeting recently and they told us how an outing had been arranged because of a suggestion they made. The registered manager told us how people's views had changed the menu choices, the type of entertainment invited to the home and the way in which some organised activities were offered.

The registered manager and staff described an approach which was focused on the individual. The emphasis was upon meaningful engagement which enhanced quality of life and helped people feel worthwhile and fulfilled. We observed a person returning from a lunch out locally who had clearly enjoyed this.

We saw photographs of people taking part in activities and people told us that staff had time to do things with them, which included spending time talking or just sitting with them and reminiscing.

The staff and people we spoke with told us that the home encouraged visitors, and that the staff supported people to maintain their relationships. For example, they would assist people to visit one another, make visits into the local community and invite relatives for meals at the home. People from the community were regularly invited into the home and the registered manager encouraged volunteers who were supported and trained so that they could offer appropriate support. During the day of our inspection we noticed that there were a number of visitors who were warmly welcomed by staff. We spoke with a health care professional who told us that they often heard about trips to interesting places in their regular visits to the home. They told us, "There always seems to be something going on at Rambla."

The service had a policy and procedure on complaints. Complaints were recorded with outcomes so that the service could provide evidence that it responded appropriately when people were dissatisfied. The registered manager said that a number of concerns were also dealt with before they needed to be followed up formally. However, we noted that some complaints which we discussed with the registered manager had not been recorded. The registered manager told us these were of a particular nature and they were devising a way of recording these which gave an overview of the themes and how these had been responded to.

Requires Improvement

Is the service well-led?

Our findings

Medicine audits were not formally recorded and therefore the registered manager could not be sure of emerging patterns in medicine handling to inform improvements in practice. Also, clinical monitoring charts were not always completed accurately with no gaps to ensure people received the care they required. Risk assessments were not always clearly linked with care plans to provide a consistent plan for staff to follow when offering care. A failure to keep clear records in relation to good governance in and was a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a registered manager in place who was qualified for the role. The registered manager was supported in their role by a deputy manager. The registered manager told us that the provider offered good support and encouraged them to discuss issues openly in a positive way.

The registered manager told us they were fulfilling two roles. One was as registered manager of Rambla Nursing Home and the other was as area manager for the provider group of homes. They discussed with us the need to delegate duties and discussed the challenge of maintaining good governance within the home when they were off site. The registered manager understood where the home could improve practice. They recognised that they sometimes did not delegate sufficiently to the deputy manager to ensure that all monitoring and updating of clinical care records was completed accurately and in a timely way. They discussed how they wanted to improve the service through sourcing further outings and in researching further training.

Most people we spoke with confirmed that efforts were made to hear and act on their views. There was a real sense that the lines of communication between people and management were open, enabling and supportive. One person told us, "They keep us up to date with what is going on."

Staff told us that the registered manager was approachable and supportive and that they were keen to listen to them and take their comments on board. The registered manager worked alongside staff so that any areas of concern could be quickly resolved. Staff told us that the registered manager actively sought their views both in meetings and informally, and that suggestions were appreciated and taken on board. Staff told us they felt valued and that every voice was respected. This included everyone who lived at the home, all staff, including ancillary staff, visiting health and social care professionals, volunteers and visitors alike.

The registered manager included the care of staff in the concept of a caring home, so that people experienced a caring and respectful atmosphere throughout the home. Staff told us that the registered manager supported them in their work and made the effort to get to know and understand them.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support. The registered manager and staff consistently reflected the culture, values and ethos of the home, which placed the people at the heart of care.

The Registered Manager told us how they updated their knowledge and practice with information from organisations recognised for advising on best practice. Before the inspection the Registered Manager completed a PIR in which they informed us in the PIR that they were members of the local Independent Care Group (ICG) and that they had enlisted with Enabling Research in Care Home (ENRICH) as part of the Research Ready Care Home Network. This showed a commitment to seeking information about best practice in care.

Communication with relatives and other interested parties was promoted through informal and formal meetings and questionnaire surveys.

Notifications had been sent to the Care Quality Commission by the service as required other than for Deprivation of Liberty confirmations, which the registered manager told us they would immediately remedy.

The registered manager carried out audits on areas of quality and safety within the home to ensure that they understood where improvements were needed. The registered manager told us that the results of audits were discussed in meetings and all staff were made aware of them so that any shortfalls were addressed to improve the overall quality of the service. Plans for improvements and progress towards achieving them were also openly shared with people who lived at the home in meetings and meeting minutes confirmed this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines handling did not always ensure the safety of people being cared for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating to the care and treatment of each person using the service were not sufficiently well kept to ensure the quality and safety of their care.