N. Notaro Homes Limited

Casa di Lusso

Inspection report

Bower Lane
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23 October 2017
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30 October 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Casa di Lusso is a purpose built 90 bedded care home specialising in the care of people living with a dementia. At the time of the inspection there were 67 people living at the home. The home is split into seven units all with Italian names, Pisa, Positano, Tuscany, Coleseum, Pantheum, Trevy Fountain and Vesuvius. At the time of the inspection the upper floor Vesuvius was unoccupied.

This inspection took place on 23, 24 and 30 October 2017. The first day of the inspection was carried out by two adult social care inspectors and two experts by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by two adult social care inspectors. The third day of the inspection was carried out by one adult social care inspector. This was the first inspection since the service registered in October 2016.

There was 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.

We found people were not always safeguarded from the risk of developing pressure ulcers. People were not repositioned in line with their care plans and when monitoring records were completed at the end of the shift the incorrect information was recorded. We raised this with the registered manager and they dealt with the issues raised immediately using the organisation's disciplinary process. Following this action we found there were measures in place to ensure people were safely supported in line with their care plans and staff had received additional support to meet people's needs.

Although there was strong leadership from senior managers and the registered manager, leadership and management of individual units was not well led. Staff responsible for leading the shifts on units failed to direct staff to carry out tasks or ensure they carried out the repositioning of people in line with their care plans. They also failed to ensure monitoring records were completed correctly.

People told us they felt safe living in the home. One person said, "Yes I feel very safe. I know the staff and they are all lovely."

There were systems and processes in place to minimise risks to people. These included a robust recruitment process and making sure staff knew how to recognise and report abuse. There were varied opinions on the staffing levels in the home, with some people saying they thought there should be more staff whilst others said they thought there was plenty of staff. Records showed that there were adequate numbers of staff available to meet the assessed needs of people in a timely manner.

People received effective care from staff who understood their needs. Some agency staff were not as clear

about people's needs as regular staff however the registered manager ensured they used the same agency staff as far as was possible so they could get to know people better.

Most staff attended induction training before they started to work in the home although some staff said they had not completed their induction before working on the floor. The care manager said they aimed to ensure all new staff attended the induction process before starting work. All staff said they had plenty of opportunities for training and the organisation also promoted dementia awareness training for all their staff.

People could enjoy a full programme of activities and staff had built up links with the local community to ensure people could stay in touch with organisations such as their place of worship and the Women's Institute. Links had also been built with a local school and college, to enable people living in the home to contribute to community dementia awareness.

People said they received care and support from caring and kind staff comments included, "The staff are very caring and respectful." "The atmosphere is very good, happy." And "Smashing this place."

People's opinions were sought on their daily care needs and the day to day running of the home. Resident and relative meetings were held and people had been asked if they wanted to form and friends of Casa Di Lusso to enable events to be organised.

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 always safe.

People were placed at risk of developing pressure ulcers because Staff did not always follow the instructions in care plans in relation to minimising risks to people. Monitoring charts were completed incorrectly.

People were protected from the risk of abuse as staff had been trained to recognise and report abuse.

There were sufficient numbers of staff to enable people to receive support in a relaxed manner.

People were protected from being looked after by unsuitable staff because safe recruitment procedures were followed.

Is the service effective?

Good

The service was effective.

People received effective care and support because staff understood their personal needs and abilities.

Staff had the skills and knowledge to meet people's needs.

People's legal rights were respected and protected.

Is the service caring?

Good

The service was caring.

People received care from staff who were kind, compassionate and made sure people were respected and their likes and dislikes were taken into consideration.

People's privacy and dignity was respected and staff were conscious of the need to maintain confidentiality.

People were involved in making decisions about their care and the support they received where possible.

Is the service responsive?

Good

The service was responsive.

People received care that was responsive to their needs because staff had an excellent knowledge of the people they provided care and support for.

People were able to make choices about most areas of their lives where possible.

People received care and support which was personal to them and took account of their preferences.

Arrangements were in place to deal with people's concerns and complaints. People and their relatives knew how to make a complaint if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Improvements were needed to ensure there was clear management and leadership in all areas of the home to promote people's quality of life and well being

Senior management provided a good approach to leading staff through example and use of best practice. However people were not always supported by staff who worked as a team. Unit leads did not direct staff and monitor their actions.

There were systems in place to monitor the quality of the service, ensure staff kept up to date with good practice and to seek people's views.

People were supported by trained and committed staff who understood the vision and values of the service.

Casa di Lusso

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

Casa di Lusso is a purpose built 90 bedded care home specialising in the care of people living with a dementia. At the time of the inspection there were 67 people living at the home.

This inspection took place on 23, 24 and 30 October 2017. The first day of the inspection was carried out by two adult social care inspectors and two experts by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by two adult social care inspectors. The third day of the inspection was carried out by one adult social care inspector. This was the first inspection since the service registered in October 2016.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

During this inspection we spoke with 19 people living at the home, 12 members of staff and six visiting relatives. We also spoke with the registered manager the regional operations manager and the care manager. We spent time observing care practices in communal areas of the home for this we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Before the inspection we asked healthcare professionals involved with the home for their feedback we received feedback from one person.

We looked at a number of records relating to individual care and the running of the home. These included six care and support plans, three staff personnel files, training and supervision records and minutes of meetings held at the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the home and with the staff who supported them. One person said, "Yes, we both feel safe. You just feel safe, a wonderful place to be in. They say you're lucky if you can get in here". Another person said, "Oh yes I feel safe, as good as anywhere else. The best of the two I've been in". A relative said, "I feel [name] is very safe, the rooms are good and there is plenty of space." Throughout the inspection people were observed to be very relaxed and comfortable with staff.

Prior to the inspection we received concerns that records were being completed with incorrect information and that staff were falsifying the monitoring records making them look like position changes had been carried out. Position changes for people who are unable to move themselves, help to minimise the risks of them developing pressure ulcers.

People's care plans contained assessments relating to risks such as falls, skin pressure damage, malnutrition and dehydration, use of bedrails and use of call bells. Some risk assessments and care plans contained contradictory information and evidence seen suggested that appropriate interventions to reduce risk were not always carried out, or recorded. For example: We reviewed the care of a person who had been assessed as being at high risk of developing pressure ulcers. Their care plan for pressure risk stated that they required the use of a pressure relief air mattress and that they needed their position changed every four hours. They also had a person centred assessment in their care file relating to preventing and treating pressure damage. This assessment suggested positional changes every three hours. A night care plan also stated "turn three hourly."

We visited the person at 10.50hrs on the first day of the inspection and found that they were asleep and lying on their right side. They had a pressure relief mattress on their bed and the inflation pressure had been set at a level appropriate for their weight. We looked at the record of positional changes for the person and found that the previous entry had been recorded at 02:30hrs that morning, when they had been recorded as being on their left side. We also saw monitoring charts, which were to be filled in every 15 minutes as the person had been deemed at risk due to being unable to use their call bell. We found that these checks had not been completed since 09:30hrs. We visited the person again at 12:03, 12:52 and 13:53hrs and found that they were in the same position and asleep. There were no further entries on their positional chart, daily monitoring chart, 15 minute check chart or food and fluid chart. We visited again at 15:30hr and found that the person was on their back and awake. No further entries had been made on any charts.

At 16:00hrs we found that some of the person's record charts had been completed retrospectively. The 15 minute checks had all been filled in. The daily monitoring chart stated that the person was 'watching TV' at 10:00 and 11:00hrs. The entry for 12:00hrs read 'having lunch.' These entries did not concur with the inspectors observations. No entries had been recorded on the positional change chart since 02:30 that morning. The food and fluid chart had retrospective entries at 13:00hrs and 15:40hrs.

We discussed the findings of our observations with the registered manager and regional operations manager. They were not aware that information was being recorded at the end of a shift and in an incorrect

manner. Following our discussions immediate action was taken to ensure that people were safe and safer working practices introduced. On the second day of the inspection we were informed that disciplinary action had been taken. We found that monitoring charts were being placed in people's rooms and all staff were aware that they had to be followed and completed when the care need had been carried out. One staff member had suggested all staff carried a notebook to ensure they could capture tasks carried out immediately. The registered manager had ensured all staff were provided with a notebook straight away. Staff showed us the notebooks and said they thought it was good idea. The registered manager explained they were exploring ways of introducing an electronic care planning system that would record when staff went into people's rooms to provide care.

Staff knew how to recognise and report abuse. All staff spoken with said they had received training in safeguarding. They said there was an open culture in the home which encouraged them to report any concerns. All felt that if they raised concerns these would be dealt with to make sure people were protected. Where concerns had been raised with the registered manager they had taken prompt action to make sure people were safe. There was information in the organisations welcome pack and staff handbook about how to raise a safeguarding concern and who to contact. However there were no posters displayed around the home explaining how people, staff or visitors could raise a safeguarding alert with the local authority. This meant the information people, relatives and staff might need was not readily at hand to assist them in raising concerns if they had any.

Risks of abuse to people were minimised because there were effective recruitment processes for all new staff. Before commencing work all new staff were thoroughly checked to make sure they were suitable to work at the home. These checks included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. Staff were not allowed to start work until satisfactory checks and employment references had been obtained.

Comments on the staffing levels in the home varied, some people said they thought there was plenty of staff others felt the home was short of staff. One person said, "I think they had a problem to start with but they seem to have enough staff around now." However another person said, "Staffing levels need to be addressed. If I ring the bell nobody can come because they are doing breakfast. I can't use the commode until after breakfast." The minutes of a staff meeting stated that if there were only three staff on a unit they did not have to take any people down for activities. This clearly showed that a shortage of staff could impact adversely on the experiences of people who might want to take part in an activity.

The clinical lead nurse said that they aimed to have four health care assistants (HCA's) on each of the four 16 bed units during the day and two at night. The two smaller six bed units would have one care worker day and night. Usually there were two registered nurses during the day and at night, one on each floor to cover both 16 bed units. An extra nurse was sometimes on duty during the week as well as the clinical lead nurse. The registered manager explained that staffing was reviewed regularly due to the home gradually increasing their occupancy. They used a dependency tool to determine the number of staff needed to meet people's specific needs. The staffing levels at the time of the inspection reflected the dependency tool and indicated that there were sufficient numbers of staff in the home to meet the assessed needs of the people living there. One staff member was concerned about the level of nurses in the home saying, "Communication can be difficult with them, trying to get hold of them." They felt this was because there was usually one nurse covering a whole floor. The home employed agency staff from a single agency. Permanent staff confirmed that they often worked with the same agency staff and they felt they had got to know people's needs. One staff member said "They know what they are doing." The registered manager also confirmed that a recruitment programme was ongoing and they had new staff scheduled to start work and more interviews

planned.

Registered nurses were responsible for the management of medicines on the nursing units. We observed a registered nurse on part of a medicine round. They demonstrated an awareness of the needs and preferences of the people they administered the medicines to. The receipt, administration and disposal of medicines were recorded electronically on a medicine management system. This meant that a clear audit trail of the use of medicines was possible and that nurses were alerted to any discrepancies, such as gaps in administration records. Two nurses we spoke with confirmed that they had received training in the systems used.

We spoke with the clinical lead nurse, who had overall responsibility for medicine management in the home. They told us of how they were working closely with the pharmacy provider to ensure that the system was working as it should, as there had been some problems since its introduction particularly with regard to ensuring people had on-going supplies of their medicines. They showed us how a daily summary was produced, highlighting any discrepancies to make sure people had access to their prescribed medicines.

Monthly audits of medicine management were undertaken by the clinical lead nurse and there had also been audits by the pharmacy provider. We saw the results of these audits and found that actions had been taken in response to findings.

Controlled drugs (CD) were kept securely and their administration was recorded in an appropriate CD register. Two signatures were evident for each administration. Weekly stock checks were undertaken by two people. We observed the administration of a controlled drug and saw that correct procedures were followed to ensure people's safety.

To ensure the environment for people was kept safe specialist contractors were commissioned to carry out fire, gas, water and electrical safety checks. There were risk assessments in place relating to health and safety and fire safety.

Risks to people in emergency situations were reduced because, a fire risk assessment was in place and arrangements had been made for this to be reviewed annually. Personal emergency evacuation plans (PEEP's) had been prepared: these detailed what room the person lived in and the support the person would require in the event of a fire.

Throughout the inspection we observed staff used personal protective clothing appropriately and washed their hands before preparing food. Alcohol gel was available throughout he home and there was very clear hand washing guidance in toilets and bathrooms.

There was a system in place to record any accidents or incidents that occurred. These would be reported directly to the registered manager so appropriate action could be taken. The time and place of any accident/incident was analysed to establish any trends or patterns and monitor if changes to practice needed to be made.

Good

Is the service effective?

Our findings

People received effective care and support from staff who had the skills and knowledge to meet their needs. People said they felt all the staff were well trained and knew their needs well. One person said, "I think they know everything there is to know." Another person said, "They are all very clever and get on with the job."

New staff received an induction including information relating to the Care Certificate and shadowing more experienced staff. The Care Certificate was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. Comments from staff about the induction and shadowing experience for them were varied. One staff member was positive about the experience. Although they had previous experience in caring, they told us they received a week's training that included moving and handling theory, fire safety, first aid, health and safety, safeguarding, mental capacity and dementia awareness. They spent time shadowing other staff who had been appointed as mentors during their shifts. They confirmed that they were not asked to do anything they were not confident to undertake. Another new staff member had a different experience. They told us "I spent a day looking at papers about things like safeguarding, fire, health and safety. The training came later. I didn't have any shadowing shifts; I was surprised but knew I could go to a senior. You always can go to someone to ask." They said that they had used moving and handling equipment before training but confirmed that this was always with a competent person. A third staff member told us that they had a full week of training after joining saying "I read paperwork on the first day and then had a week's training. It was quite good. The dementia training was good. I was supposed to shadow but felt I got thrown in at the deep end to start with." The care manager explained how they aimed for all new staff to complete the induction training before they worked on the floor to make sure they had the basic skills required to effectively support people.

All staff confirmed they had access to plenty of training opportunities. This included the organisations policy for staff to attend updates of the their statutory subjects such as, manual handling, medication, safeguarding vulnerable adults, infection control, health and safety, food hygiene, first aid and nutrition. One staff member said they felt the training was very good and they liked the fact it was face to face so they could ask questions and work though scenarios. The care manager explained how they worked on the floor and could provide training on the spot when needs were identified. As well as the organisations mandatory training records showed staff had attended training in PEG feeding, use of thickeners in drinks, and the use of food supplements. The care manager said they had also put in plans for training in writing care plans for care workers. Staff also confirmed they could obtain a qualification in health and social care provided by the organisation. This all helped to make sure staff had up to date knowledge and skills to enable them to safely and effectively support people.

Staff told us they had received enough support from the registered manager to meet people's care needs. The registered manager completed an annual appraisal for each member of staff to discuss their performance, training needs and where improvements were required. They also completed one to one supervision meetings on a more regular basis as well as regular team meetings when wider issues could be

discussed. For example we saw record keeping and care plans had been discussed at one staff meeting.

Staff had received training about the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Staff spoken with were aware of the need to assess people's capacity to make specific decisions. Where appropriate they had involved family and professional representatives to ensure decisions made were in people's best interests. Care plans contained assessments of people's capacity to make certain decisions and where necessary, for example the provision of some equipment, a best interest decision had been made.

Staff sought people's consent before they assisted them with any tasks. During the day we heard staff asking people if they were happy to be assisted. For example when assisting a person to move staff clearly explained what they were doing and asked the person if they were happy with the help. People told us staff asked for their consent. One person said, ""Yes, they do ask permission. They always ask you first."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made when necessary and the registered manager had followed up decisions with the local authority. When a DoLS application was accepted the registered manager completed the necessary notification to CQC.

People's nutritional needs were assessed and weights were monitored. If a person was seen to be losing weight a GP review would be arranged. Food supplements could be prescribed if appropriate. One person had been assessed as being at high risk of malnutrition, had swallowing problems and required staff to assist them to eat. Records seen showed that their weight had remained steady over a sustained period of time showing the care plan in place was effective in meeting their needs..

Everybody spoken with said the food in the home was good. One person said, "The food is very good. I get a choice. I can have a sandwich if I don't like what's on the menu." We observed the mealtime experience to be relaxed and a social event for people who sat in the communal dining rooms. One person who chose to sit alone refused to eat their main meal and staff gave them time to change their mind before offering them the next course. People who choose to eat in their rooms were supported appropriately and the care plan for correct positioning for one person was followed correctly. Nobody appeared to be rushed and people who needed assistance to eat were supported with dignity and respect.

Special dietary needs could be catered for to meet either health related needs or cultural needs. Staff were all aware of any special dietary needs for people such as diabetic diets and vegetarian options were available for people to choose from. People confirmed a choice of meals was available and one person explained how they hadn't felt like anything on the menu so asked for a jacket potato instead which they said had been very good.

A registered nurse was always on duty with care staff to ensure people's nursing needs were monitored and met. People saw health care professionals when they needed them. Records of visits or contacts with healthcare professionals, such as general practitioners, nutrition nurses, physiotherapists and podiatrists were seen in peoples care files.

All areas of the home were well lit and there was signage to enable people to find their way around. Toilet and bathroom doors were clearly labelled with pictures to enable people to find the right rooms. People's rooms also had memory boxes outside so they could relate to something that would remind them that it was their room.

Good

Is the service caring?

Our findings

People said they were supported by kind and caring staff. One person said, "Yes, they know us as individuals. Very caring staff. Very respectful. Always knock the door and maintain your dignity". Another person said, "The staff are always very polite and charming". There was a cheerful and relaxed atmosphere in all areas of the home and staff communicated with people in a very kind and respectful manner.

People were treated with dignity and respect. All the staff were observed to support people to make choices about their day to day lives and they respected their wishes. We also observed staff were respectful, understanding and patient when assisting people. They addressed people by their preferred name, responded promptly to requests, such as for a cup of tea, and most staff took the time to talk. For example one person wanted to assist with the washing up after lunch. Staff supported them to do this at their pace. Another staff member was observed to help a person make their own cup of tea. People told us they were given choices at all times, one person said, "Yes, I do have a say, they always listen to you. They give you advice. It's like a little family, it's lovely and yes I do have enough information to make a decision."

It was clear regular staff knew people well. Staff were able to tell us about people and their individual lifestyle choices and wishes. However some agency staff did not know people so well and were unable to tell us about their needs. One agency staff member was observed to just sit in the communal area watching TV. They did not interact with the person sat next to them. This was bought to the attention of the registered manager at feedback.

People's privacy was respected. Each person had their own bedroom. This meant staff could support people with their personal care needs in the privacy of their own bedroom. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home.

Staff spoke warmly and respectfully about the people they supported. They were careful not to make any comments about people of a personal or confidential nature in front of other people. Staff understood the need to respect people's confidentiality and to develop trusting relationships. Individual records were securely stored to protect people's personal information.

A record of compliments was kept by the home. We looked at some of the compliments they had received. Relatives were generally very happy with the care and support provided and a sample of the comments made included. "Thank you for your excellent care of [name] done with so much dignity and understanding." One relative thanked the registered manager for the support they gave when selecting the home. They had been able to take photographs and a video of the room so their relative could make an informed choice. Another comment finished, "…we are also grateful for the love and compassion you gave us as a family." Relatives were also encouraged to share their experiences with other organisations and locally, for example one relative shared their experience through a local radio. They had written in the carehomes.co.uk feedback, "[The person] was very frail, lost a lot of weight and wanted to die. Your wonderful staff soon changed that. [The person] was made to feel so special, encouraging her to eat and get back her lovely sense of humour. We were also made very welcome and the staff were always ready to listen

and answer our questions, which were many."

The home was able to care for people at the end of their lives. The care plans gave information about how and where people wished to be cared for at this time. Advance care plans and information about people's wishes regarding resuscitation had been signed by people or their representatives to show they agreed with the plan in place. The registered manager explained how they could also offer relatives the opportunity to live in when a person was reaching the end of their life this enabled people to have their friends and relatives close to them at such an important time.

There were ways for people to express their views about their care. People told us they were involved in reviews of their care plans and could say how they preferred their care and support to be provided. One relative told us they were always involved and kept informed they also confirmed they were involved in the care plans. The registered manager held regular resident/relative meetings where people could discuss the day to day running of the home. The minutes for a recent relatives meeting were available in the reception area. The minutes showed they had discussed specific training needs around stoma care, links with the local school and the formation of a Casa Di Lusso friends group to organise events. Following the meeting the registered manager had arranged for staff to receive additional training in managing stoma care.

The provider carried out an annual quality assurance survey for people and their relatives where they could share their views. As the home had only been operating for one year this was in the planning stage. However following concerns raised with CQC the registered manager had carried out a survey of people's experiences at night to feed into their investigation. The result of the survey showed people were largely satisfied with the care and support they received from the night staff.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. People were supported to make choices about most aspects of their day to day lives.

People were supported to take part in activities and hobbies that they were interested in. During the inspection we observed care staff supporting people to take part in activities of their choice. One unit was holding a skittles morning whilst in another area people were reading the newspaper and discussing the news. In another unit people were looking at books and discussing holidays. One staff member sat down with one person and discussed any changes they might like to make to their care plan in line with their dietary preferences, whilst generally chatting about seasonal food and how they had enjoyed gardening. One person's care plan was very clear about their daily routine which involved them going to the home's small holding and feeding the animals. This helped them manage their behaviours that could challenge so they would feel settled for the day. During the afternoon of the first day people from all units joined to take part in a sing along with an outside entertainer. People appeared to be enjoying themselves and the atmosphere was relaxed.

Following the inspection the activities organiser told us, "The activities team within Casa work tirelessly to promote and provide person centred activities that lend themselves to the interests of each of our residents. I developed a campaign with an objective of demonstrating how fun, exciting and wonderful it is to live in a care home, with a strap line of a 'Little bit of what you fancy does you good'." For this campaign the activities organiser needed people to experience the activities so an awareness campaign could be promoted. Members of the local Women's Institute (WI) agreed to be models for the photography session and some of the people living in the home joined in. Following the session a tea party was arranged so people living in the home could present a cheque to the WI's charity of the year which was the local blood bike service.

The homes extensive gardens were also put to good use in the summer when a garden fete was held to which people invited their friends and relatives and members of the public. The activities organiser told us, "Various activities, stalls and musical entertainment was organised and the home was decorated with bunting, balloons and banners. The event was advertised outside the home, and was attended by lots of local people along with their children, as well as relatives and friends of the home. The party atmosphere lasted all day, as residents enjoyed delicious party food and cream teas, whilst getting involved in all sorts of activities. The home and residents decided it would be nice to raise money for a chosen charity, and between staff and residents it was decided to raise money for local charity, Brainwave."

An activities programme for the week was displayed on the outside of the door of each unit however there was no advertising of activities in the units for people to see this meant people were unable to make an advanced choice about the activities they might like to take part in. However care workers were observed telling people what was happening and asking if they wanted to join in.

Before people moved to the home they were visited by a member of the management team to assess and

discuss their needs, preferences and aspirations. This helped to determine whether the home was able to meet people's needs and expectations. People and their representatives were encouraged to visit the home before making a decision to move there. We met one person who moved in during the inspection. Their relative had been able to visit the room and take pictures for them so they could see what it looked like. The registered manager had made it possible for their relative to move their personal effects in the day before so everything was set up similar to the home they had come from with their own furniture books and pictures. The registered manager also provided a bunch of flowers as a welcome gift. The person said they thought that was, "a very nice touch, I feel so welcomed."

From the initial assessments care plans were devised to ensure staff had information about how people wanted their care needs to be met. Some people were able to tell us they had been asked about their wishes when they first came to live at the home. One person said, "I am involved in everything, and I have my say."

The care plan format provided a framework for staff to develop care in a personalised way. We observed care was provided in a very caring way however it failed at times to fully address specific issues such as the need for repositioning.

People's care plans had been based on an assessment of their personal needs. Those seen included 'Person Centred Assessments' that related to general needs, such as communication, expressing needs, moods and emotions, thinking and deciding, and relating with others. Care plans were in place where a need had been identified. Where people had specific clinical needs, such as a percutaneous endoscopic gastrostomy (PEG) feeding tube, or diabetes; we found that specific care plans were available. One person's plan for care of their PEG tube lacked some detail with regard to routine care, however we saw records to suggest that were following the correct procedures in order to prevent problems with infection and adhesion.

A person who was diabetic and required insulin injections was having their blood glucose levels monitored regularly. There were protocols in their care plan that informed staff of actions to be taken should their blood glucose reach a certain level, which included contacting the persons GP for advice. We saw records that indicated these protocols were followed on an occasion when their blood glucose was found to be high. Care plans also contained some information about people's previous lives in the form of a life history. Information on how they liked to spend their day was also recorded. Records seen in the form of a 'monthly review of well-being and audit of care plan' indicated that people's care plans were reviewed monthly.

The provider had a complaints procedure which was displayed in the home. People said they felt they could raise concerns and make a complaint if they needed to and the service responded to them. One person said, "I see [the registered manager] about I can talk to her if I think something is not right. "Another person said, "Can talk to anyone I guess they are all good at listening." One relative said they felt that smaller issues were not always acted on as quickly as they could be. They explained how they had had to ask repeatedly for things like the chiropodist and dentist before they had been actioned.

The registered manager explained that they spoke with people and relatives personally most days so anything they were not happy about was dealt with immediately and did not become a complaint. The homes policy and procedure for raising concerns gave clear time scales for response and any action taken. We saw complaints had been dealt with in line with the homes policy and learning points raised at staff meetings.

Requires Improvement

Is the service well-led?

Our findings

There was 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.

There were systems in place to ensure people received care and support from a team that was well led. The management team consisted of a registered manager, a care manager and a clinical lead.

Each unit had a team lead who was responsible for overseeing the day to day running of the unit. However the team leads/senior staff on the individual units did not take responsibility for ensuring the care staff carried out their duties in line with people's care plans. We found nurses in charge of units did not check that staff had carried out repositioning in line with peoples charts. We also observed one agency staff member sitting in the communal area watching TV without interacting with people, this member of staff was not approached by a senior staff member at any stage to allocate work. We discussed this with the registered manager at the same time we discussed the poor and incorrect record keeping that care staff were maintaining. The registered manager and regional operations manager took immediate action to investigate the issues we had identified and consulted their HR team on the correct course to take. This showed that the registered manager dealt with the issues of poor care immediately and improving the outcomes for people living in the home.

There was a quality assurance system in place to monitor care and plan on-going improvements. There were audits and checks in place to monitor safety and quality of care. We saw that where shortfalls in the service had been identified action had been taken to improve practice. For example audits of care plans showed the registered manager had identified issues with record keeping and monitoring charts before the inspection. We saw this had been raised as training and discussion points at staff meetings for all staff including the qualified nurses. This meant all staff were given the same message. This showed the registered manager was supporting staff to recognise and use best practices to support people. However team leads/senior staff had not developed any way to put these practices in place on the individual units and this had not been identified until the inspection visit.

All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

Most staff felt well supported by the registered manager and provider. Staff comments about the management of the home varied. Most staff spoke highly of the registered manager with comments such as, "It's an open door policy with [the managers]. Staff meetings can be twice monthly including unit meetings." Another staff member said, "They listen. They come to you the next day to discuss any concerns raised." However one staff member said of the manager "She gets stressed; she needs to step back a bit and listen to what people say."

During the inspection we did identify one staff member who went above and beyond what was expected of them to provide support for the care staff on all of the units. We mentioned this to the registered manager as an example of exemplary working practices.

The registered manager and provider promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. A copy of the homes policy and procedure for the Duty of Candour was available in the entrance for people, staff and visitors to read. This demonstrated the organisations approach to being open and transparent.

There were robust systems in place to share information and seek people's views about the running of the home. These views were acted upon where possible and practical. Resident meetings were held regularly and people's views acted upon. Following a recent meeting people were consulted about the food they would like included in the winter menu list. Relatives were asked if they would like to form a friends of Casa Di Lusso so events could be organised encouraging involvement from family, friends and the local community.

The registered manager was in the process of building strong relationships with the local community. They had contacts with the local church, and a local school, where they were planning to develop the Archie project, "The Archie Project is an exciting intergenerational dementia awareness project that links local primary schools, care homes/ sheltered housing schemes, businesses/ services and community members to ultimately dispel the fear and stigma often associated with dementia and create more dementia friendly communities." Also in the planning stage was contact with the Bridgwater College nursery where, "It is hoped that very soon our residents will be visiting Bridgwater College on a weekly basis to meet, engage and develop friendships with the nursery children of the college." They also built up relationships with the local Women's Institute (WI), for activities and fund raising.

The service had worked alongside and established links with health and social care professionals to ensure people received the best care possible. One visiting healthcare professional said they had built up a very good relationship with staff. They felt they listened and were happy to discuss any ideas they had to improve experiences for people. Another healthcare professional told us, "The home staff are caring, thoughtful and knowledgeable about their patients. The staff will work productively with us to achieve better lives for the residents. Nothing is a no go area and they will attempt and try new ways of working with people. I have a lot of admiration for [the registered manager] in taking on this project and she has done well."

The registered manager was supported by the regional operations manager who would provide them with their one to one supervision meetings. At these meetings they could discuss the progress being made with staffing and bed occupancy as well as concerns raised and how they were managed. Staff also confirmed that a system of one to one supervision meant they could discuss training needs and any issues regarding the care and support they provided or the running of the home. This also gave the registered manager the opportunity to share best practice training and guidelines with staff either on a personal basis or in group supervision.

The management team attended local provider groups which enabled them to keep up to date with local initiatives and share good practice with their own staff and other providers. The management team also kept their skills and knowledge up to date, though research and training, and through manager meetings within the organisation when they could share what went well and what they did about things that did not go so well.

The registered provider ensured the home was run in line with current legislation and good practice guidelines. There were up to date policies that were available to all staff to make sure they had the information they required to provide safe and effective care.

To the best of our knowledge the provider has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.