Somerset Care Limited

Polars

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 12, 27 and 30 November 2015 and was unannounced.

Polars is a residential care home for people requiring personal care. A maximum of 37 people can be accommodated at Polars and at the time of our inspection there were 32 people living in the home, some of whom had physical disabilities or were living with dementia. Care is provided over two floors, with two lifts providing access to the upper floors. On the ground floor there are several communal lounge areas, a hair salon, a dining room and a garden.

The home had a registered manager. 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.

Risks to people's health and wellbeing were not effectively assessed and action was not taken to reduce the risk. People's care plans did not always reflect current risks to people and were not reviewed regularly.

Summary of findings

People were given their medicines in a sensitive and patient manner but medicines were not always administered safely. Some medicines were not given according to the manufacturer's instructions. Topical creams were not stored appropriately to prevent the spread of infection and infection control measures in relation to commodes were not followed.

Safe recruitment practices were in place which ensured staff were subject to appropriate checks before started working in the home. However, a shortage of staff and a lack of organisation of staff in the home resulted in some people waiting for extended periods for staff support. Senior staff had covered care shifts and as a result had not had time for other duties, such as staff supervision and care reviews. The provider was not prompt in providing support for the registered manager and staff.

People said they felt safe in the home and with staff. Staff were knowledgeable about the signs of abuse and how to report their concerns. Most staff showed a kind and caring manner to people and respected their right to privacy. Staff asked people for their consent and respected their decisions but processes to protect the legal rights of people who lacked capacity to make decisions for themselves were not always followed.

Staff felt supported by the registered manager but opportunities for staff to receive formal supervision were limited and their training needs were not identified and met in a timely manner.

Food was plentiful and varied and people said they enjoyed the meals and desserts. A choice was offered and people could choose where to take their meals. Activities were varied and people said they enjoyed them; however, people were not always consulted about their choice to participate or not.

Staff knew people well and had built good relationships with people living in the home. People said they currently had no complaints, and records showed when a complaint was received this was addressed in a timely manner.

People's feedback was sought but their comments were not always acted on. Audits were not carried out systematically and as a result improvements were not always made where needed.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems to manage risks to people's health and wellbeing were not up to date and their care did not always reflect these risks. Staff organisation was poor and resulted in some people often waiting for long periods for assistance from staff.

Medicines were given to people in a discreet manner but they were not always administered safely and according the manufacturer's instructions. Infection control procedures were not followed in relation to the cleaning of commodes.

Staff were aware of signs of abuse and what action to take in response to concerns. People said they felt safe in the home and with staff.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not receive regular support and training for some staff was overdue.

Staff were aware of the need to gain people's consent to care and respected this; however, processes designed to protect people's legal rights were not followed.

People were given a variety of meal choices. People's health was monitored and staff responded when people required medical attention.

Is the service caring?

Requires improvement

The service was not always caring.

Some interactions between staff and people lacked compassion. People were not always given the choice to opt out of planned activities.

People felt staff were kind and listened to them. People were given privacy when they wanted and staff took care to respect people's dignity.

Is the service responsive?

Requires improvement

The service was not always responsive.

Some people's care plans were not up to date and did not cover all their care needs.

People's individual preferences were recorded, known by staff and respected.

People were confident that complaints would be taken seriously. When a complaint was received this was dealt with in a timely and comprehensive manner.

Summary of findings

Is the service well-led?

The service was not always well-led.

Support from the provider was lacking and had led to senior staff and the registered manager covering care staff shifts.

Some quality assurance measures were in place, but improvements based on people's feedback were not always acted on.

The registered manager supported staff and fostered an open culture in the home.

Requires improvement

Polars

Detailed findings

Background to this inspection

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

This inspection took place on 12, 27 and 30 November 2015, was unannounced and was carried out by an inspector, a specialist advisor in the care of older people, and an expert-by-experience in the care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the home. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We also reviewed notifications about important events which the home is required to send us by law and our previous inspection report.

We spoke with nine people living in the home and nine relatives / visitors. We received feedback from three health care professionals who visited the home. We also spoke with five care staff; the cook; a housekeeper; a care assistant; the activities co-ordinator; the deputy manager and the registered manager. We observed how care was delivered in communal areas and reviewed eight care plans and associated records of care. We also reviewed the provider's policies and procedures, accidents and incidents record, medicines administration, staff duty rosters and two staff recruitment files.

Inadequate

Is the service safe?

Our findings

People felt safe in the home and visitors felt their relatives were cared for safely. They said staff took care of them well. Whilst some people said staff attended to their needs promptly, other people and some visitors expressed concern over staffing levels in the home.

Risks to people's health and wellbeing were assessed and recorded on people's computerised care and support plans but these were not always up to date or reviewed appropriately. The registered manager said a person's falls risk assessment should be reviewed every six months, or following a fall. For one person who had had two falls in the previous fortnight, their falls risk assessment, dated 21October 2014, had not been updated to reflect this. The person's falls history record was inconsistent and contained contradictory information about the person's medical history. Another person had fallen on 6 November 2015 and no falls risk assessment had been completed for them. This meant measures to prevent further falls had not been assessed and implemented.

People were not protected from the risk of malnutrition; this risk had been assessed and guidance was available for staff as to what action to take according to the level of risk. One person had been identified as at 'medium risk' of malnutrition and had been recorded as losing four kilos of weight over four months. The risk assessment guidance stated that the person should be 'weighed fortnightly' to monitor their weight more closely, and, 'improve, and monitor their nutritional intake'. The person's weight record showed they had been weighed at intervals of between one and two months. Their food intake had not been monitored and staff were unaware of the person's need to increase their food intake. Two other records showed similar unplanned weight losses for people who were at medium or high risk of malnutrition. For one person their eating and drinking care plan stated, "I have put a little weight on", when in actual fact they had lost almost three kilos in the preceding four months.

Several people had been diagnosed with tablet or diet controlled diabetes. Eating and drinking care plans for two people said they should be provided with a low sugar and low fat diet. The cook said they were not aware of anyone with health-related dietary requirements including the need for low sugar or low fat options. One person's care plan stated their blood sugars should be monitored if their health changed or they had other 'cause for concern'. The person's blood sugars had not been monitored since 21 September 2015 despite them being unwell recently. The normal range of their blood sugar level was not recorded so it could not be established if their levels were higher or lower than usual and no action was recorded for staff to take should the person show signs of being unwell.

People at risk of falls were not always provided with the support they required to reduce their risk of falling. People were able to call for staff assistance by pressing their call bell. One person's care plan stated that the person should be 'encouraged to use their call bell' as they were at high risk of falls if they mobilised without staff assistance. At times, staff response to the person's call bell was delayed. On one occasion, the person summoned staff assistance and their call bell was not answered for seven minutes. After four minutes the call bell automatically switched to the emergency tone. The registered manager said that when a call bell sounded as an emergency staff should attend the person immediately which staff did and found the person had fallen in their room. On another occasion the same person waited 11 minutes for staff to arrive to provide support. Records showed that other people experienced similar and longer waiting times, up to 24 minutes, before staff attended to them. Staff reported that they were unable to hear the call bell when they were in a particular part of the home. Two staff were allocated to provide care to the 12 people living in this part of the home. Five of the 12 people required two staff to support them and staff reported that if they were in one of those rooms the bell could not be heard. This meant that at times they would not have been able to hear an emergency call bell until they had exited the room. One person said their call bell was left unplugged and they were left for half an hour trying to attract staff attention. They said a passing member of staff eventually attended to them and said another member of staff had forgotten to plug the call bell in. However, they made no record of this and did not report it the management and as a result this incident was not investigated in order to prevent this from happening again. When we drew this to the deputy manager's attention they reported this to the local safeguarding team.

The failure to assess and manage risks to people's health and wellbeing was a breach of regulation 12 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Some people said they felt there was a lack of staff in the home for some time. One person said they felt that they were, "sometimes forgotten" by staff. A visitor said, "Staffing levels are good today but it is not always as well-staffed". Another visitor expressed concern that staff were available in some parts of the home and neglected other parts. They said, "Staff tend to be in the top lounge, not in the other two [lounges]". Nine of the responses from the provider's June 2015 quality assurance survey of people living in the home, relatives and health professionals mentioned concerns over a lack of staffing and long waits when people operated their call bell. They referred to, "frequent staff shortages", "more staff to answer call bell", and, "not enough staff at mealtimes".

At times there appeared to be a shortage of staff in particular areas of the home. During the morning medicines round we heard a person calling out persistently for assistance from a room situated at the end of a corridor on the top floor of the home. There were no staff in the vicinity and the person was not using their call bell. They were calling out from 8:15am. We found a member of staff and told them the person was calling for help to go to the toilet. They told us they would attend to the person straight away but only did so at 8:39am with another member of staff. People waited in excess of half an hour in the dining room between the advertised time of the lunchtime meal and their meal being served. On four occasions we observed people calling out from the dining room, either requiring assistance to move from there, or asking to be taken to the toilet. On one occasion a person became distressed because they had not been helped to the toilet in time saying to staff, "You left me too long!" In another instance four staff were involved in finding a person's cushion. No member of the carer team took a lead to direct the search in a logical manner.

The registered manager said they worked out the number of staff required based on people's needs. They had taken action to restrict the number of people admitted to the home when there had been a serious shortage of staff, and had only recently started accepting additional people into the home. Because of the shortage of care staff, senior staff had covered shifts. The registered manager said that whilst they thought there were sufficient numbers of staff working in the home, there was a skills gap and due to the number of inexperienced staff employed senior staff were still required to work alongside staff to ensure people's needs were met.

The failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection prevention and control measures were not always followed by staff. Staff were observed carrying used commode pans through the home to the upstairs sluice. This presented an infection control risk to people. The registered manager said this was not the home's procedure and explained that the used commode pan should be placed in a red bag and then taken to the sluice room to be cleaned. The provider's commode cleaning procedure did not refer to either practice and the registered manager said the policy was not appropriate to the home. They added that they would review the procedure to ensure that staff were using safe processes to protect people from the spread of infection.

Topical creams which people had been prescribed were kept in a box in the medicines room. One box contained a tube of cream which was used for intimate care. The tube of cream had no lid on and the inserter part of the tube was loose in the box. The tube of cream had been used but it was unclear whether the inserter had been used. Another cream product in the box was also stored without the lid on. This meant there was a risk of infection transfer to other products in the box. No infection control audits had been completed.

The failure to assess the risk of, and preventing, detecting and controlling the spread of infections was a breach of regulation 12 (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a recent outbreak of diarrhoea and vomiting which had affected several staff and people living in the home. Staff had followed the 'lock-down' procedure which included extra personal protective equipment (PPE) such as disposal aprons and gloves, and restricting visitors from entering the home.

Some aspects of medicines administration were not safe and did not meet people's needs. The care delivery records for one person indicated that they were in pain on three consecutive nights. The person was not offered pain relief and there was no record that the concerns about the person's pain were communicated to senior staff or the registered manager. Some people had been prescribed 'as and when necessary' (PRN) medicines. These included pain

Is the service safe?

relief in varying strengths and medicines to reduce anxiety. There was no guidance for staff about the circumstances under which the person should be offered these medicines, what effect the medicine was expected to produce and what action to take if the desired effect was not reached. Two people had been prescribed a medicine which must be given on an empty stomach and the person should have no food and fluid for thirty minutes afterwards. Both people were given this medicine together with at least three other medicines. This is contrary to the manufacturers' instructions and not the most effective way to provide this medicine.

Medicines administration records (MAR) for four people contained numerous gaps in signatures. The signature of the member of staff administering the medicine serves as a record that they have seen the person take their medicine. A member of staff told us they felt, "sure the medicines had been given", and that this was a recording error.

The home's policy for the administration of medicines was dated 2013. This meant it did not include the National Institute for Clinical Excellence (NICE) guidelines 2014, which were not being followed by staff. For one medicine used to treat anxiety disorders, the number of tablets in stock did not match the stock record and it was unclear whether there were tablets missing or not.

The failure to ensure administration of medicines was safe was a breach of regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The storage of other medicines was appropriate. Medicines controlled by law were stored securely and the records maintained were accurate. The temperature of the medicines room was recorded daily in a book along with the temperature of the refrigerator used to stored medicines that were required to be kept cool. The provider had an efficient system of ordering new stock; a medicines disposals book was maintained and products for disposal were stored safely.

People received their medicines in a caring manner. The member of staff administering medicines approached people discreetly and explained to them what their medicine was for and asked for their agreement before giving the person their medicines. They waited for the person to swallow their medicines and did not rush them. When a person complained of pain a member of staff asked them what kind of pain they were experiencing, whether they would like one or two tablets and offered to take them to a quieter area of the home.

People felt safe in the home. Safeguarding Information was displayed publicly. Staff had a good knowledge about the meaning of safeguarding to the people living in the home and of the signs that may indicate abuse may be taking place. They knew what to do to report concerns and how to escalate their concerns if appropriate action was not taken by the management. They were familiar with whistle-blowing and how this was, "an important part of safeguarding because reporting things that are wrong helps to keep people safe". Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The personal effects, including items of value, of one person who had passed away had been left in a vacant room. When we brought this to the attention of the deputy manager they immediately removed the items for safe keeping and said they would contact the person's family.

Recruitment practices were safe. Staff suitability checks were undertaken before staff were employed in the home. These included references from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions.

A personal evacuation plan (PEEP) had been created for each person which covered their ability to hear, raise and respond to a fire alarm; the assistance they required to leave the building and whether they were able to use the stairs. Accidents and incidents were recorded and analysed each month to determine whether there was a pattern developing that could prevent falls for example. Records of care delivery showed that where people required equipment to mobilise safely this was used by staff. Staff used equipment in a safe manner and confirmed they had been trained to use the stand-aid and the hoist. A stand-aid that could not be used safely had been clearly labelled as 'out of order' to ensure staff did not attempt to use it.

Requires improvement

Is the service effective?

Our findings

People felt confident that staff knew how to care for them and said their needs were met.

The registered manager said they aimed to carry out six supervision meetings a year with each member of staff, either personally or delegated to a supervisor. The regularity of supervision for staff was inconsistent; one staff member received supervision on a monthly basis over a period of three months, whilst others reported they had not had a supervision meeting for some time and records confirmed this. All but one member of staff had not received regular supervision in the previous six months whilst two staff had not had a formal supervision meeting for more than a year and another for 10 months. Formal opportunities for staff to discuss any issues relating to their role and training needs were therefore lacking. The registered manager said staff could access them at any time; however, we observed that the registered manager spent a lot of their time in providing care to people and opportunities for staff to discuss issues in any detail were limited.

Staff training was delivered by the provider's in-house training company and by an external provider. The registered manager said the external provider carried out unannounced observations on some staff practice. They had reported that a member of staff had used inappropriate manual handling techniques with one person. Although the member of staff had been removed from any further moving and handling manoeuvres, a supervision meeting had not been held with them to discuss the concern. Some training, which the registered manager said was refreshed on an annual basis, was overdue or had not been completed at all by some staff; two staff had not completed manual handling training for more than a year; training for one member of staff in the safeguarding of adults was more than a year overdue and for two others between four and six months overdue. A further member of staff said they had not completed training in the safeguarding of adults at all and the registered manager said the member of staff had refused to do this. Some training dates were planned and staff had signed up to this; however, the registered manager was not clear about what training was required by which staff, and training appeared to be arranged on an 'ad hoc' basis.

The failure to ensure staff received appropriate support, training, supervision and appraisal was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff had completed a course in dementia awareness and reported that it was, "excellent", and, "a real eye-opener". They said it helped them to get some understanding of the experiences of a person living with a diagnosis of dementia.

All new staff were enrolled to complete the Care Certificate and two staff had completed this. The Care Certificate provides care staff with the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. New staff were provided with a mentor who supported them through their first few weeks in the home. The induction programme for new staff included 'shadow' shifts with a more experienced member of staff, and training covering safeguarding, the Mental Capacity Act, first aid, manual handling and care plan writing. After two weeks the new staff's performance was reviewed, and again at six weeks.

Some staff were unclear how the principles of the Mental Capacity Act 2005 (MCA) should be applied in the home. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. One member of staff was clear about the principles of the act and how to care for people who may lack capacity. Other staff were not clear about the principles and said they would refer to the registered manager if they had questions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the home was not meeting the requirements of DoLS. The manager had made applications for DoLS authorisation for 11 people. However, people's mental capacity had not

Requires improvement

Is the service effective?

been assessed prior to the DoLS application and therefore people's legal rights were not protected. Staff were not clear about the implication of a DoLS and how to ensure people's rights were protected under the safeguard.

People said they enjoyed the choice and quality of the food. They commented, "The food is good; ask for what you want and you will get it. There's always squash available", and, "I had toast and prunes for breakfast today, that was my personal choice. At weekends I usually have eggs and bacon". People were given a choice of breakfasts; four types of cereal, porridge; toast and jam or marmalade; fresh fruit or cooked items if this was their preference. Two choices of meal were offered at lunchtime, as well as a hot and cold option for dessert. Meals were presented in an appetising manner.

The atmosphere in the dining room was relaxed and sociable and people were not rushed. The dining room was set out in a restaurant style with tables of various sizes. Staff provided encouragement and support to eat where people required this, and were attentive to people's needs during the meal. Where it was evident that a person was not eating much of their meal, they were offered an alternative. When people had finished their meal staff asked if they would like a further serving before clearing the person's plate away.

The cook was aware of people's preferences, such as their likes and dislikes. The provider had a corporate menu in place and the cook adapted this to provide people with their preference. For example, if people didn't like fish in batter, they would offer smoked fish as an alternative. They said, "If someone says they like 'this or that' then we try and work it into the menu". One person was served chips with their lunchtime meal instead of the advertised boiled potatoes according to their choice. Care staff told people what the choices for lunch and tea were and people's choices were recorded. If people were not keen on either choice then an alternative was provided, such as an omelette, jacket potato or cold meat salad. For tea, choices of sandwiches and soup were offered as well as a salad option.

Drinks stations were available in the lounges, with various types of fruit squash and water available. A 'corner shop' was available once a week where people could purchase additional items of food and drink, and sundry items. A beverage trolley was in use mid-morning and mid-afternoon when people were provided with a hot drink and a variety of biscuits.

People had access to support according to their health needs. Appointments with chiropody, district nurses and the GP were recorded and people said they could see a doctor whenever they needed to. A visiting health professional said staff were knowledgeable about people's health conditions and made appropriate referrals for medical help. Another health professional said staff, "care for people according to our guidance".

Requires improvement

Is the service caring?

Our findings

Most staff provided care in a compassionate manner. Staff smiled at people, behaved warmly towards them and appeared to have a good rapport with people. Visiting health professionals said, "Staff are caring; they have the personal touch", and, "They are brilliant at caring". People expressed that some members of staff, and the registered manager, were, "good, caring people". Visitors said they had only ever observed good interactions between staff and people and that staff, "talk nicely to people; very caring". We observed visitors and family members were welcomed warmly by staff.

Whilst people told us staff were caring, our observations showed that some staff were not sensitive to people's needs. A person called out to staff for assistance to move from the dining room. A member of staff who was not trained to support people to move told the person that they could not help them, but then failed to look for a member of staff who was able to provide the appropriate support. Another staff member said to a person, "What are you doing? You can't do that!" when the person attempted to move themselves in their wheelchair. The person responded, "I can do that; I need the toilet". Two staff who were discussing the location of a person's cushion were heard to say in front of the person, "If the cushion is not here [the person] can't have one".

Other staff were attentive to people's needs in a warm manner. One person was supported by a member of staff to enter the dining room in their wheelchair. The staff member said, "Are you ready? In your own time". They waited for the person to get comfortable and then said, "I'll just push you into the table, okay?" The member of staff then greeted each person in the dining room by name and checked they were comfortable, and had their needs met before leaving the dining room. Another member of staff assisted a person who was partially sighted. They directed the person verbally to locate the bowl, spoon and cup in front of them, reminded them that the tea would be hot and said, "Your cornflakes are just how you like them, nice and crunchy". When the area where people were sitting quietly required some maintenance that would cause some noise, staff offered people to move to a quieter area of the home if they wished.

The activities co-ordinator said they looked at people's care plans and observed their capabilities to inform their schedule of planned activities. However, people who were sitting in the lounge where activities were taking place were not given the choice of whether to join in the activity or not. One person, whose disability meant they were not at ease with the activity chosen by the member of staff, was made to join in until we intervened. The person said, "I cannot see the ball and was afraid of it coming or me hitting it at another resident".

When staff offered people choice they respected people's decisions. People could choose where they wanted to spend their time, when they wanted to get up or go to bed and if they wanted to have a bath. One member of staff said to a person, "Would you like to sit in an arm chair [person's name]". The person replied, "Whatever is easiest to you". The staff member responded, "It is your choice". A staff member told us "We don't force anyone to go to bed; it's their home", adding that people came into the home with a routine and they tried to help them continue in that routine if this was their wish. We observed staff asking people if they needed anything and responding to people's decisions about where they wanted to be and what they wanted to do.

Relatives said their family members were cared for in a kind manner and they were kept informed about their health. One relative said their family member had been reluctant to use their call bell when they required help to go to the toilet. Because staff has reassured the person and frequently asked them if they would like assistance, this encouraged the person and now they were, "happy to [call for staff] at night". Another relative said, "When [my relative] is up the care home rings so that I can visit".

The registered manager sat with people to eat the same meal that they were eating. They had meaningful conversations with people, and shared their food when a person next to them expressed their like for a vegetable the registered manager didn't like. The person said, "I really like parsnips". The registered manager said, "I don't, would you like mine?" The person enjoyed the extra vegetables and the registered manager told the person that more could be brought from the kitchen if they wished.

The home had received several 'thank you' cards from relatives of people who had lived in the home, and these were displayed. These expressed thanks for "the wonderful care", and "Excellent care, kindness, attention and love" given to their relative.

Requires improvement

Is the service caring?

People said they had privacy when they needed it and could spend time in their rooms as and whenever they wanted to. One person said, “I go to my room with my visitors because it is more private”. Reminders to staff and people about ‘what dignity means’ were posted around the home with examples of good and poor practice in terms of respecting people’s dignity.

Staff talked to people about their personal needs in a discreet manner, for example, when asking people if they would like to go to the toilet. When a person asked for pain relief, the staff member knelt down next to them and spoke in a lower tone close their ear. Once their needs were established the member of staff reassured the person they would obtain their pain relief and offered to take the person to a quieter area so they could relax; the person accepted this offer.

Staff offered people clothes protectors at their mealtime and their decision to have one or not was respected. If a person dropped their serviette, or some food, staff were quick to attend to the person.

Requires improvement

Is the service responsive?

Our findings

People said staff knew them well and gave them the care they required. A relative said they were, "always involved in discussions" about their family member's health and care needs. Visiting health professionals said staff had, "a good knowledge of each [person] and of their [medical] history", and told us "The manager always makes sure they see us before we leave, to get an update from us".

Whilst people said their care needs were met, their care was not reviewed regularly. The registered manager said that people's care plans should be reviewed every month and by senior staff at least every six months. None of the care plans we looked at had been reviewed at these intervals. People's care records were computerised and care staff were required to update people's records when care was delivered. We looked at six people's records and found that some did not include up to date information about the person's needs. The records for one person showed that they lived with the effects of dementia, emphysema and the loss of sight in one eye. There was no guidance for staff about how to support them specifically with their dementia or emphysema and no guidance for staff about how they should approach the person in the light of their visual impairment. Another person lived with a terminal illness but there was no care plan which related to the care and support the person may have required regarding this. We spoke with two care staff who told us, "We cannot access the computer but we have a really good handover each day and because we are a stable team we know [people] really well. If there is something we do not know we can always ask". The registered manager was aware that people's care plans were not all up to date and said they would address this.

A handover book was used to communicate information on people's health and care needs, especially if these had changed. We spoke with a member of staff following a shift handover meeting, and they were aware of people's needs in the area of the home where they were working. However, not all messages were communicated to staff effectively, and at times, details about people's care needs were not passed on to staff. For example, one person had an unexplained bruise, which according to the registered manager should have been monitored by staff, but had not been noted in the handover book, or in handover notes. Staff said there were too many places to record concerns, and it had become confusing. One member of staff said, "This [system] needs to be streamlined". Staff did take action when they were concerned about a person's health or well-being. Feedback from health professionals via the provider's annual survey stated, "Carers are quick to report the deterioration of clients", and, "Carers report the need for pressure relieving equipment". A relative stated, "Recent changes in [my relative's] needs have been discussed with us".

The level of support people needed was recorded in their care plans and staff cared for people according to their preferences Where people were able to do some tasks independently these were recorded and daily records of care showed staff encouraged people to do these tasks. Most people made decisions about where to spend their time, and staff responded to people's daily choices. For example, records showed when a person, "did not want to get up", their breakfast was served to them in their room, and we observed people being given the option of whether to move to a dining chair rather than sitting in their wheelchair. Records also showed that people chose what clothes they wanted to wear. Staff were familiar with people's preferences. One staff member said, "I know how people want their drinks; where they want their tea served, things like that". A 'Tell your story' scheme had been initiated to encourage people to record their life history. One person had done this and staff said they had found this to be beneficial to help them to, "get to know" the person better.

People had formal opportunities to give their views on the care they received. A 'You said, we did' arrangement was in place where people were encouraged to make suggestions for improving the home. People had made suggestions which had been implemented; these included 'more activities daily' and 'having vegetables served on the plate rather than in a central dish'. The provider had responded by employing a second activities member of staff and ensuring people's vegetables were served on their plates at mealtimes. 'Residents' meetings' were planned occasionally, and sometimes notes were taken. The last recorded meeting was in June 2015; however, the registered manager said another had taken place since then.

A schedule of activities showed what was planned for each week day, with activities at the weekend currently being introduced. Representatives of local churches regularly

Requires improvement

Is the service responsive?

came to the home to provide services to people as they required. Other activities arranged included bingo, cooking, flower arranging and songs with piano accompaniment which people sang along to. This was clearly an enjoyable activity and lots of people joined in. A hairdresser visited each week.

In quieter areas of the home, people did puzzles or listened to music. One person said, "There is lots to do. I am knitting squares to make into a blanket". Others commented, "I love [the activities]…I really liked dressing up as a witch [for Halloween]", and, "I love a good sing-along". People engaged in a flower arranging session, with a person designated as 'judge' of the final arrangements. There followed a discussion about what people could plant now for autumn colour and what they could do for next spring. This encouraged people to think ahead and plan for the future which they appeared to enjoy. In the previous year people had entered a local flower competition and won a 'highly commended' award for the hanging baskets which they had made.

The activities co-ordinator adjusted the activities schedule according to how people were feeling. For example, on a particular day some people had received a flu vaccination and didn't feel like doing the activity that was scheduled. The co-ordinator instead chatted with people about their first boyfriend or girlfriend and their younger days. People who wanted to were enabled to be involved in a knitting project which raised funds for local services, and produced various craft products which were for sale in the home to raise funds. Some activities were designed especially for people with memory loss, and others had been organised specifically for people who had experienced a stroke with representatives of the Stroke Association. Other activities were adapted to accommodate people's limitations; larger print, wipe clean crossword puzzles were available for people with sight problems. If a person had a particular interest, other people were asked if they wanted to get involved. A visitor said, "[The activities co-ordinator] enables people to maintain their interests and gets others to join in". They gave an example of a person who liked brass rubbing. The activities coordinator supported a group of residents to join in brass rubbing with the person.

People said outings were arranged less frequently than before, and the activities co-ordinator explained that due to the increased needs of people and the size of the vehicle available, they had been unable to arrange as many trips as they would like. They had arranged people's attendance at a 1940s Tea dance taking place locally. People waiting to go expressed enthusiasm about, "getting out, listening to a bit of music" and although no longer physically able to dance, "watch people dance, that'll be lovely". A further trip to a local attraction had been arranged for the following week. Staff and people supported the home to raise funds. One person said, "We help with the fete. [Named staff member] puts hours into the fete to raise funds".

People had no complaints about the home, but they said they would complain to staff or the registered manager if they needed to. One person said, "I have moaned; most things are recorded", adding that "I think it is all over now". Complaints were recorded and investigated with written or verbal feedback given to the complainant. Where possible, action was taken immediately to remedy the issue. If the issue involved a member of staff, the staff member received supervision to make sure the issue did not become a complaint again.

Requires improvement

Is the service well-led?

Our findings

People spoke positively about the way the home was run. They said the registered manager was visible and available if they wanted to talk to them. Relatives said, "I think the care home is well-operated and well-run", and "[The registered manager] really cares".

Some audits were undertaken, but these were limited in scope and were in response to an issue being raised. For example, a cleanliness audit had been undertaken following a complaint about the cleanliness of a person's room. An audit of that room was carried out and issues were addressed promptly; however, the audit did not extend to other areas of the home. A check on infection control procedures may have shown that staff were not following all of the home's policies and procedures.

People's care records had been reviewed in June 2015. The registered manager acknowledged people's care had not been reviewed at the intervals the provider required. The June 2015 review had identified a number of issues with missing information in people's care records. A list of what was required to remedy this had been produced, however the actions had not been carried out to ensure that records relating to people's care needs were accurate and up to date.

An action plan had been drawn up following a survey of people living in the home. People had made numerous comments including, 'food could be more appetising'; 'more staff to answer the call bell'; 'bring in more staff' and, 'improvement in foot care'. Whilst the registered manager was aware of the comments, no action had been taken to follow these up with the people who had made them or to improve the service.

The failure to assess, monitor and improve the quality and safety of the service was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The external training provider carried out some unannounced observations on staff practice to check that training was embedded in staff practice. Where issues requiring attention were noted these were had been recently reported to the registered manager for action.

Weekly checks were made on equipment to ensure these were maintained in a safe condition. If an issue was found this was attended to and records showed that maintenance was carried out promptly. Notifiable events in the home were made to CQC in a prompt manner.

The registered manager felt under a lot of pressure and, due to several months of staff shortages, had been working as a care worker in the home. They had not had time to oversee senior staff who had also been required to spend more time providing care to people. As a result senior staff duties including staff supervision, audits and people's care reviews had not been completed regularly. Both the registered manager and staff expressed how the extra pressure had had a detrimental effect on staff practice and morale.

A survey of health professionals who visited the home regularly showed that the management was approachable and that they would personally recommend the home to others. Staff said they felt supported by the registered manager, and the senior care team. They commented, "[The registered manager] is a good listener; if you have a concern you can go to her immediately", and, "If I have any problems I go and see [the registered manager]", adding, "the problem was sorted". Other staff commented, "[The registered manager] is a good, solid manager", and they are, "open to debate, new ideas; and willing to trial new ways of doing things". The registered manager said of staff, "Staff are important and we need to make them feel that way".

The provider's company values were stated as, 'Customers, Candour, Care'. These values were reflected some, but not all, staff practice. Staff felt able to own up to mistakes and felt they would be supported to make improvements. They said, "[The registered manager] has an open door policy; nothing is hidden", and, "I can approach anyone here", and, "It's [people's] home, they do what they want to do". A poster on display declared the home's commitment to 'be increasingly aware of and helpful to people with dementia'. The registered manager said they worked on the floor all the time observing staff attitude to people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in the home. Staff did not always receive appropriate supervision and training Regulation (18) (1) & (2) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider failed to assess, monitor and improve the quality and safety of the service provided. Regulation 17 (1) & (2)(a) & (e)**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to people's health and safety were not assessed and managed safely. Regulation 12 (1),(2)(a)(b).

The enforcement action we took:
We have issued the registered provider and registered manager with a warning notice to be met by 31January 2015.