Alpha Care Castlemaine Limited

Castlemaine Care Home

Inspection report

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Ratings

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

Overall summary

When we carried out an unannounced comprehensive inspection at Castlemaine Care Home on the 06 and 11 November 2014, breaches of Regulation were found. As a result we undertook an inspection on 23 and 24 November 2015 to follow up on whether the required actions had been taken to address the previous breaches identified. We had also received concerns from a whistle blower about staffing levels, increase of falls and poor moving and handling of frail people, which we looked at during this inspection.

Castlemaine Care Home provides accommodation and personal care for up to 42 people living with differing stages of dementia who also have health needs, such as diabetes. Castlemaine Care Home is owned by Alpha Care Castlemaine Limited who have one other care home in Kent. Accommodation was provided over two floors with a passenger lift that provided level access to all parts of the home. People spoke well of the home and visitors confirmed they felt confident leaving their loved ones in the care of Castlemaine Care Home.

After our inspection of November 2014, the provider wrote to us to say what they would do to meet legal requirements in relation to assessing and monitoring the

Summary of findings

quality of service provision, safeguarding, delivering appropriate care and did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users.

We inspected Castlemaine Care home on the 23 and 24 November 2015. There were 26 people living at the home on the days of our inspection.

Whilst we found improvements had been made to meet the previous breaches, we found regulation 17- Good governance was not fully met and breaches of other regulations.

We had received a number of concerns from various sources prior to the inspection. These concerns were regarding low levels of staffing, increased number of falls and unsafe moving and handling practices. We found there were concerns in these areas during our inspection.

Some people made complimentary comments about the service they received. People told us they did feel safe and well looked after. However, our own observations and the records we looked at did not always match the positive descriptions people had given us. Some of the relatives we spoke with were happy with the service being provided and others had concerns about staffing levels, "Staff seem to be rushing, it can get very busy in the afternoons."

The provider did not have an effective system to check how many staff were required to meet people's needs and to arrange for enough staff to be on duty at all times. Staff told us and we observed that there were not enough staff to meet people's needs. We saw that people on the first day of the inspection were not supported with their meals and drinks. People were left unsupervised in communal areas and interaction between staff and people was rushed. People then exhibited signs of frustration and mental withdrawal.

Staff told us the home was usually well managed but changes in the service lately had caused staff to be concerned and they felt communication systems were failing. They told us that they had raised written concerns and were waiting for a response on the first day of our inspection. The provider confirmed that he had received the letter of concerns that day and that was the reason for his arrival at the home.

Quality assurance systems had not been effective in recognising shortfalls in the service. Improvements had not been made in response to accidents and incidents to ensure people's safety and welfare. Accidents records identified an increased number of unwitnessed falls in October 2015 to November 2015. These had not been followed up with a plan of action to prevent a reoccurrence.

People's weights were being monitored accurately to make sure they were getting the right amount to eat and drink, However the recent lack of appropriate support at meal times meant there was a risk of people experiencing malnutrition and dehydration. There were mixed views about the meals, some people were complimentary but other people were not so impressed. One person told us, "I can't eat this, it's too difficult to manage on my own." A visitor said, "I come at meal times because the staff struggle to help everyone, so I help my mother."

There were a wide range of person specific care plans and risk assessments in place. However we found that some peoples increased health needs had not been reflected in their moving and handling risk assessments which had the potential to put the persons and staff members' safety and well-being at risk. .

Advice from health care professionals had been sought in a prompt manner when people showed signs of illness.

Records relating to people's care and the management of the service were well organised and safely maintained.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. At the time of the inspection, the registered manager had applied for DoLS authorisations for people living at the service. Staff had a good knowledge of their responsibilities with the procedures of the Deprivation of Liberty Safeguards and were aware that people had had applications to have their liberty deprived. Procedures had been followed in relation to the Mental Capacity Act 2005. People had been supported to complete a mental capacity assessment before decisions were made on their behalf. A mental capacity assessment determines if a person has the capacity to make specific decisions about their lives.

Summary of findings

Staff had received the essential training and updates required to meet people's needs. This included training in the Mental Capacity Act 2005 (MCA) and preventing and managing behaviours that were a risk to the person or others.

People were protected from the risk of abuse. Staff had received training or guidance relating to the protection of vulnerable adults. Staff were clear of the actions they should take if they identified or suspected abuse. They were also aware of whistle blowing procedures to raise concerns.

Safe recruitment procedures had been followed to make sure staff were suitable to work with people. These checks ensure people were safe to work with vulnerable people.

Information regarding complaints were easily accessible to people and their relatives. Complaints that had been raised had been recorded. There were systems to make sure prompt action was taken and lessons were learned to improve the service being provided.

People some of whom were living with dementia were usually provided with meaningful activity programmes to promote their wellbeing. Staff had worked together to provide communal environment that was colourful, comfortable and safe. There was visual signage that enabled people who lived with dementia to remain as independent as possible. People were supported to maintain their relationships with people that mattered to them. Visitors were welcomed at the service at any reasonable time.

We found that the management of medicines was safe and people received the medicines prescribed to support their health and well-being.

The delivery of care was based on people's preferences. Care plans contained sufficient information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. Information was available on people's preferences.

People we spoke with were very complimentary about the caring nature of the staff. People and visitors told us care staff were kind and compassionate.

Feedback had been sought from people, relatives and staff. Residents and staff meetings were now being held on a regular basis which provided a forum for people to raise concerns and discuss ideas

The overall rating for this provider is 'Inadequate'. It means that Castlemaine has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of breaches 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 

Castlemaine Care Home was not safe. We found that the breaches of regulation identified in November 2014 had been met, but found new breaches of regulation that placed people at risk.

People were placed at risk from equipment which was not suitable for their needs and poor moving and handling techniques.

There were not always enough suitably qualified and experienced staff to meet people's needs. People's needs were not taken into account when determining staffing levels.

Risk to people had been assessed, however not all risk assessments had been updated to reflect people's changed needs. This had placed people at risk.

Medicines were stored safely and people received their medicines when they needed them.

Is the service effective?

Requires improvement 

Castlemaine Care Home was not consistently effective.

People's nutritional needs were not always met. People could choose what to eat and drink on a daily basis. However the meal times were not enjoyed by people nor were people supported by staff in an appropriate way that ensured people ate and drunk enough to remain healthy.

People spoke positively of care staff, and told us that communication had improved with staff.

Staff received on-going professional development through regular supervisions, and training that was specific to the needs of people was available and put in to practice on a daily basis.

Staff we spoke with understood the principles of consent and therefore respected people's right to refuse consent. All staff working had received training on the Mental Capacity Act 2005 (MCA) and mental capacity assessments were consistently recorded in line with legal requirements. Deprivation of Liberty Safeguards (DoLS) had been submitted and there was a rolling plan of referrals in place as requested by the DoLS team.

Is the service caring?

Good 

Castlemaine Care Home was caring.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

The manager and staff approach was to promote independence and encourage people to make their own decisions.

Summary of findings

People were encouraged to maintain relationships with relatives and friends.

Relatives were able to visit at any time and were made to feel very welcome

Staff spoke with people and supported them in a very caring, respectful and friendly manner.

Is the service responsive?

Requires improvement

Castlemaine Care Home was not consistently responsive.

Whilst care plans showed the most up-to-date information on people's needs, preferences and risks to their care, some risk assessments did not fully reflect changes to people's mobility needs.

People told us that they were able to make everyday choices, and we saw this happened during our visit. However whilst there were meaningful activities planned for people to participate in as groups or individually to meet their social and welfare needs, these did not happen due to staffing levels. Extra staff on the second day of inspection meant planned activities took place and were enjoyed by people.

Staff were seen to interact positively with people during our inspection when they had sufficient time. It was clear staff had built rapport with people and they responded to staff well.

Is the service well-led?

Inadequate

Castlemaine Care Home was not well-led. People were put at risk because systems for monitoring quality were not effective. This was a continuing breach of regulation.

The home had a vision and values statement, however due to changes in staffing levels this was not being fulfilled.

People, staff and visitors spoke positively of the care, however, commented that staffing levels could impact on the running of the home.

The culture of the care team was open and transparent. Staff understood the management structure of the service, who they were accountable to, and their role and responsibility in providing care for people. The manager told us they were supported by the provider who visited the service on a weekly basis.

Castlemaine Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

We undertook an unannounced inspection of Castlemaine Care Home on 23 and 24 November 2015. This inspection was to check that improvements to meet legal requirements planned by the provider after our inspection in November 2014 had been made.

The inspection team consisted of two inspectors. During the inspection we met and spoke with 11 people who lived at the home, five relatives, six care staff members, the provider and the registered manager. We also had contact with the Quality Monitoring Team of social services.

We looked at all areas of the building, including people's bedrooms, bathrooms, the lounge areas and the dining areas. Some people had complex ways of communicating and several had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the records of the home, which included quality assurance audits. We looked at five care plans and the risk assessments included within these, along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's receives and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service safe?

Our findings

At the last inspection in November 2014, the provider was in breach of Regulation 9 and 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which now correspond to Regulations 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care delivery was not safe and the registered person had failed to respond appropriately to safeguarding matters.

Due to the concerns found at the last inspection, an action plan was submitted by the provider that detailed how they would meet the legal requirements by 30 September 2015. At this inspection we found improvements had been made and the provider was now meeting the requirements of Regulations 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However we found that people were still at some risk of not receiving safe care and treatment.

Before this inspection we had received concerns that the two slings used with an electrical hoist (moving equipment) had been condemned and were not to be used. We were told that this meant people were not being moved safely. We were also told that one person was being lifted manually by staff placing the person and staff at risk as there was no equipment in the home to lift the person safely. We found moving and handling practices did not always ensure people's safety. We observed a person being supported to move from an armchair to a wheelchair without the support of appropriate equipment. Staff told us that this was normal procedure as the person could not stand and there was no equipment suitable to move the person with. They told us that they lifted the person under their legs and arms to lift them. This placed both staff and the person at risk from injury. We looked at this persons care plan and risk assessments. The risk assessment had not been updated to reflect the persons' increased frailty or inability now to stand and take their own weight.

Slings for the electrical hoist had been found to be unsafe for use due to wear and tear by the hoist supplier on the yearly check. There were no other slings available for staff to use. We asked staff how they managed without the slings and were told, "We lift people manually." Staff knew this to be unsafe and were unhappy about it. They told us they had written to the provider who confirmed that he had received the letter from staff that morning and would be addressing the issue. We were told by the registered manager that new slings had been ordered. During the discussion in respect of slings we found that slings were used generically in the home and not individual to each person. This meant that there was a potential cross infection risk (skin infection and viral infections) as slings were not cleaned between use. We also found that a fabric recliner chair in the communal lounge was odorous and badly stained. Staff told us that it belonged to one person however, it still needed to be clean and hygienic for use to avoid cross infection and unpleasant odours.

An accident and incident audit spreadsheet had been introduced since the last inspection. This identified time of fall, outcome of fall and for some people, preventative measures were put into place, such as half hourly checks at night. However this was not in place for all people. There was a lack of follow up for people who had unwitnessed falls and robust preventative measures had not been put in place. For example one person had had six falls between 11 November 2015 and 20 November 2015. The records stated 'closer observations had been requested', and 'observe when mobilising as unsteady'. However, it did not state how staff were to observe or what closer observations were. There was no documented evidence of any monitoring having been undertaken. Staff told us that monitoring was difficult due to staffing levels. The care plan and risk assessment had not been updated to reflect these falls.

Risks relating to people had not been assessed or acted upon. This was a breach of Regulation 12(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the inspection we received information that staffing levels had been decreased in the past month and this had impacted on the safety and wellbeing of people. We were told that there had been an increased number of falls and staff were worried that they could not meet people's needs adequately. The registered manager confirmed that staffing levels had been decreased and that staff had raised the concerns with the provider on the day of the inspection

At this inspection we found that there were not sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. Castlemaine Care home had 26 people living on two floors and there were three staff teams to cover 24 hour care. The morning shift was covered by five care staff (two seniors and three care staff), in the afternoon the staffing levels reduced to four care staff and

at night to three care staff. The rota also demonstrated that there was a reliance on agency staff who had limited knowledge of the people and their needs. The staffing levels had not been assessed against the dependency levels of the people who lived there. There were three people, whose needs had increased significantly recently and required full assistance with all aspects of care, including the use of an electrical hoist. There was no evidence to show this had been taken into consideration when calculating staffing levels.

We were told by visitors that staffing levels were not sufficient to keep an eye on people in the lounge areas. One visitor said, "I think that the staffing levels are a problem, I see staff having to rush around and often there is no staff to be seen." A staff member told us, "we are really struggling, not enough staff." We observed in the lounge five people were sat for long periods of time with no interaction from staff. Two people were asleep for the majority of the observation whilst three people sat with nothing to do, one person was becoming agitated whilst another was staring into the distance. Staff had not had the time or opportunity to provide a meaningful activity as they were still attending to personal care. We undertook a further SOFI in the afternoon and the four staff were unable to supervise the communal areas and support people who were mobile and saw examples of people becoming bored and agitated as they had nothing to do. Staff told us that the activity person would usually be providing an activity for people but was currently off work. Staff also told us that there was no time to do anything with people as the staffing levels did not give them the time to. One staff member said, "It's so busy in the afternoons as people get a little restless and tired, it's difficult to keep people safe." On the first afternoon of the inspection there was an unwitnessed fall in the upper part of the large communal area. Staff were not in the vicinity. The layout of the communal areas provided quiet areas for people but we noted and staff confirmed that it was difficult to supervise people. The deployment of staff had not ensured peoples safety.

We looked at accident records that identified a significant increase in the past month. We saw evidence of up to 42 falls, 85% were unwitnessed by staff. Falls had been recorded but not analysed. On examination the majority (34 of 42) of falls were evening and night time. This indicated that staffing levels in the evening and night were not sufficient to monitor and keep people safe.

We observed that lunch time was busy and that staffing levels were not sufficient to assist people with their meal. We saw that people that needed assistance were left with their meal in front of them for up to 15 minutes uncovered. One person was trying to eat on their own but were unable to manage, another person got frustrated with not being able to eat and pushed it away uneaten. During the meal time we also observed a staff member standing between two people's recliner chairs and assisting each person at the same time. Neither of the people had been sat up in a suitable position as there were not enough staff in the communal area to ensure that this happened. We immediately brought this to a senior care staff member's attention who went and addressed the situation. The staffing levels were not sufficient to ensure that people were supported to meet their nutritional needs.

People had personal emergency evacuation plans (PEEPs) which detailed their needs should there be a need to evacuate in an emergency. However these did not reflect the reduced staffing levels or the increased needs of people. This placed people at risk.

There was not enough staff to meet people's needs safely at all times. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of the inspection staffing levels had been increased and we received confirmation from the provider and registered manager that the staffing levels would not be reduced.

There were a range of risk assessments in place to ensure peoples safety. Risk assessments for physical and mental health related needs were in place, such as skin integrity, nutrition, poor memory, behaviours that may challenge, falls and dependency levels. Care plans demonstrated how people's health and well-being was being protected and promoted. We saw detailed plans that told staff how to meet people's individual needs. For example, a person who was at risk from falls had a pressure mat in their room that alerted staff the person was up and moving. Another person was displaying problems with eating and drinking and there were clear directions of how to minimise the risk of dehydration and malnutrition.

Care plans were computer generated and then printed off and placed in individual folders. The files were then available should there be a problem with the computers.

Inadequate

Is the service safe?

However care plans and risk assessments were not all reflective of people's current needs and therefore had the potential to place people at risk from out of date information. For example, changes to mobility and weight loss. One person had been continuously losing weight, staff were providing fortified food and drinks, the G.P was aware and involved and staff were monitoring. However this was not recorded. Staff told us they relied on handover information as the computers were sometimes not working and there was not always time to read the paper care files. Staff told us that they felt the documentation had improved but admitted they still had areas to work on. However, whilst improved there was still further work to do to ensure that people's changing needs were documented as changes occurred.

Staff supported people with their medicines. We observed the midday medicines being given to people. We saw senior care staff administer medicines safely. Medicines were administered from a trolley which was kept locked when not in sight of staff. Each person was approached individually by the staff and asked if they were ready for their medicines. Staff were interrupted at times by people approaching them for assistance but they did follow good practice and ensure the medicines were stored safely before attending to the people.

All other systems relating to medicines were safe. This included safe and secure storage of medicines. There were clear systems for people to receive their medicines when they went out of the home, with a full audit trail. Where people were prescribed medicines on an 'as required' basis, there were clear protocols available to staff to show when people should be given such medicines and how often. One person was prescribed medicines to be given in an emergency. There were clear instructions of when such medicines were to be given and the actions staff were to take.

Where people were prescribed topical medicines such as creams, records were completed and demonstrated that the people's skin conditions had been treated as prescribed. Staff recorded the administration of prescribed drink thickeners along with clear instruction of the consistency required to prevent the risk of aspiration.

Safeguarding policies and procedures were up to date and appropriate for this type of home in that they corresponded with the Local Authority and national guidance. There were notices on staff notice boards to guide staff in whom to contact if they were concerned about anything and detailed the whistle blowing policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest.' Staff told us what they would do if they suspected that abuse was occurring at the home. Staff confirmed they had received safeguarding training. They were able to tell us who they would report safeguarding concerns to outside of the home, such as the Local Authority or the Care Quality Commission.

People were cared for in an environment that was safe. There were procedures in place for regular maintenance checks of equipment such as the lift, firefighting equipment, lifting and moving and handling equipment (hoists). Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Health and safety checks had been undertaken to ensure safe management of food hygiene, hazardous substances, staff safety and welfare. Staff had received regular fire training which included using fire extinguishers and evacuation training.

Requires improvement

Is the service effective?

Our findings

At the last inspection in November 2014, the provider was in breach of Regulations 18 and 23 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2010, which now correspond to Regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of mental capacity assessments and DoLS referrals and the provider had not given staff suitable opportunities to express concerns and consider their training and therefore staff may not have had the training necessary to deliver

care effectively.

The Provider submitted an action plan detailing how they would meet their legal requirements by 30 June 2015. Improvements were made and the provider was now meeting the requirements of Regulations 18 and 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However we found that that staff lacked oversight of people's food and fluid intake and people did not have the assistance required to enjoy their meals.

People were complimentary about the food and drink, and everyone we spoke to told us, they had enough to eat and drink. Positive feedback included, "Good food," and I think the right amount." We were also told by staff that menus and food times were being discussed regularly to ensure people were eating what they wanted at a time that they wanted.

The meal service observed at Castlemaine Care Home was not a shared experience or made to feel like an enjoyable event for people. Due to changes in people's ability to eat independently and staff deployment it had become a task to get through rather than something to be looked forward to. Staff lacked oversight of what people were eating and drinking. People were left to manage on their own struggled to eat as there were no plate guards to aid them and they couldn't manage with a knife and fork. One person fell asleep in their chair with their meal untouched in front of them. Staff told us that the meal times were difficult as more people now required assistance and prompting. One staff member said, "We all know it's not working very well but we do try." Following discussion with the staff team on the first day of the inspection a tiered meal approach was in place on the second day. This approach worked well and we saw that staff had the time to assist people to eat their meal. We also saw that feedback about aids to assist people had been taken forward. For example plate guards and adapted cutlery. This had enabled certain people to eat independently whilst prompted by staff. The meal observed on the second day of the inspection was a much more enjoyable event for people. This was an area that was identified as requiring improvement and embedding into everyday practice.

There was a choice of meals offered. The menus demonstrated a varied and nutritious diet. The staff were aware of people's preferences and the chef had a good understanding people's needs and their likes and dislikes.

Staff had received essential training in looking after people, for example in safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity and moving and handling. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were found competent to work unsupervised. Training for staff included specific training for supporting people who lived with dementia, managing behaviour that challenged, and end of life care. Staff also told us that they received teaching sessions about different illnesses such as diabetes and strokes. They told us they had learnt many things to enhance their care delivery. For example managing different people's behaviours and trying different methods to ensure people's needs were met in the best possible way. However despite moving and handling training staff told us they were manually lifting one person. Staff demonstrated an awareness of why this was not safe but felt there was no alternative as they needed to deliver care and move the person to prevent pressure damage. They told us, "The slings we have are not the right ones for this person due to their new physical disabilities." This was discussed with the provider and registered manager. They told us that they understood that the person had fluctuating moving and handling needs and were in the process of requesting a further moving and handling assessment. We received confirmation following the inspection that this had been progressed. We were also informed that the person was not being manually moved and that a special sling had been purchased to suit the person's specific requirements.

At our last inspection in November 2014, we found that the registered person did not have suitable

arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation

Requires improvement

Is the service effective?

accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. This inspection demonstrated that staff understood the principles of consent and therefore respected people's right to refuse consent. Staff were understanding and patient of people who initially refused assistance by allowing them time to settle and approaching them again to gain their participation or consent. We saw one person refuse to their meal. Staff removed the food and just sat and chatted before asking, "Would you like me to help you with your lunch now." The person was happy this time to accept the help. We spoke with staff about how they assured people were happy to accept support. One staff member said, "Our residents are all very individual and we know them well, and know what their responses mean." Another All staff working had received training on the Mental Capacity Act 2005 (MCA) and mental capacity assessments were consistently recorded in line with legal requirements. Deprivation of Liberty Safeguards (DoLS) had been submitted and there was a rolling plan of referrals in place as requested by the DoLS team. We had received regular updates from the manager informing us of DoLS applications. The care plans contained mental capacity assessments and DoLS applications that have been completed.

At out last inspection in November 2014, we found that staff had not been receiving regular supervision. This inspection found that staff had received supervision regularly. We also saw a rolling programme of booked supervisions. Staff confirmed they received supervision. We were told that due to the recent retirement of the deputy manager, some staff supervision was slightly behind but was in the process of being rearranged. A new deputy was being recruited and supervisions would be divided up amongst the management staff to ensure all staff received timely supervision.

Records showed that people had regular access to healthcare professionals, such as GPs, chiropodists, opticians and dentists and had attended regular appointments about their health needs. People we spoke with confirmed this. One person said, "I have regular chiropody and eye tests." We also saw letters of referral to SALT and dieticians. Staff told us that one person was to be re-assessed as their needs had increased and they now needed nursing care.

Emergency plans were in place and understood by staff. Each person had a personal evacuation plan which included details about their level of mobility and the allocated place of safety in the event of a fire. The registered manager told us that they or a senior member of staff could be contacted in the event of an emergency. There were clear instructions for staff to follow, so that the disruption to people's care and support was minimised in the event of an emergency situation occurring. This included having a "This is me" document for each person for use out of hours. The document included details of people's medicines and a summarised version of the person's medical history, ability to communicate, individual needs and abilities and behavioural guidelines, if appropriate.

Good

Is the service caring?

Our findings

People and their relatives spoke highly of the care received. One person told us, "The staff are caring." A relative told us, "I'm happy with how care is provided." Another visitor told us, "Staff listen to people and are kind and supportive to people."

We found that staffing levels had impacted on how the staff interacted with people and delivered care. It was evident on the first day that staff were rushed, and that they didn't have the time to offer support and reassurance to people. However when staff were supporting people, it was undertaken in a caring and kindly way. People were comfortable with staff and the SOFI undertaken on the second day when staffing levels had been increased showed us that staff approached people regularly and interaction between staff and people was positive. We saw people reacting to the stimuli provided by staff in a way that was missing from the previous day. We heard jokes being exchanged along with good humoured banter.

People's dignity was promoted. People's preferences for personal care were recorded and followed. We looked at a sample of notes, which included documentation on when people received oral hygiene, baths and showers. Documentation showed that people received personal care in the way they wished. People confirmed that they had regular baths and showers offered and received care in a way that they wanted. One person said, "They know how I want my care given, I think they are good here." Care plans detailed how staff were to encourage people to wash and dress themselves to promote their independence. This involved prompting and encouraging them to choose their own clothes. One visitor told us, "Staff have really worked hard together to give people the care they need and in a way that demonstrates they care."

People's need for privacy was promoted and their privacy respected. For example, staff ensured that people's dignity was protected when moving people from a wheelchair to an armchair. We also saw that people's personal care was of a good standard and undertaken in a way that respected their privacy. When prompting people to visit the bathroom staff talked in a quiet manner ensuring that other people did not hear. Relationships between staff and people receiving support consistently demonstrated dignity and respect. Staff understood the principles of privacy and dignity. Throughout the inspection, people were called by their preferred name. We observed staff knocking on people's doors and waiting before entering. Staff were patient and responsive to people's mood changes and dealt with situations well by using diversional tactics and a kind word.

Staff demonstrated they had a good understanding of the people they were supporting and they were able to meet their various needs. One staff member told us, "The residents are great, we've got to know each person, their likes and dislikes." Staff were clear on their roles and responsibilities and the importance of promoting people to maintain their independence as long as possible. One staff member told us, "We always try and keep people to be independent. For example, we'll always encourage people to wash themselves or do as much for themselves as possible." Another person said, "we try to encourage people to socialise with each other, and it's really rewarding to see friendships develop."

People were offered choices and enabled to make safe use of all communal areas of the home. Families told us they felt welcomed and were always treated with respect and offered refreshments. We spoke with visitors who said, "The staff here are very good, it may not always run smoothly as people can change moods very quickly but the staff care." Another relative said, "I know from experience how difficult it is to manage someone who keeps forgetting, but the staff here are so patient, and kind." Another relative said, "The staff here treat me and my family like we matter as well, really appreciate their kindness."

Bedrooms were clean and homely, many contained family photographs and personal ornaments. One visitor confirmed that they had been encouraged to bring in personal mementoes and photographs.

Care plans showed that family and people's involvement had been sought where possible, and personal preferences had been recorded on admission to the home. These set out people's preferences within an activity plan based on the activities of their life before arriving in the home and when they reached the end of their life. We saw that people's food choices reflected their culture and religious choices. People's personal preferences for lifestyle choices, such as food and drink, activities and interests were being updated to reflect changes to their health and well-being.

The manager told us that an advocate would be found if required to assist people in making decisions. They also

Good

Is the service caring?

told us they had information to give to people and families about how they could find one if it became necessary. This ensured people were aware of advocacy services which were available to them.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time. The registered manager told us, “There are no restrictions on visitors”. A visitor said, “I come in each day and the staff always welcome me.”

Requires improvement

Is the service responsive?

Our findings

People and their families told us that the service responded to their needs and concerns. One visitor said "I only have to mention a problem and it's dealt with," and another said "We can talk to staff at any time, about anything." Complaint handling was an area identified as needing improvement at our last inspection in November 2014.

This inspection found that records demonstrated that comments, compliments and complaints were monitored and acted upon. Complaints had been handled and responded to appropriately and any changes and learning were recorded. The procedure for raising and investigating complaints was available for people. One relative told us, "If I was unhappy I would talk to the management, they are all wonderful". One senior care staff member said, "People are given information about how to complain. It's important that you reassure people, so that they comfortable about saying things. We have an open door policy as well which means relatives and visitors can just pop in."

We were told that activities, exercise classes and visiting entertainers were arranged and people could choose what they did every day. However the activity person was currently off work and the staff deployment had not allowed staff to facilitate any activities. We observed that people were left with no stimulation or meaningful activity during our first day of inspection. Some people became restless and bored which caused other people to exhibit behaviours that challenged. Staff told us, "We haven't had the time to prepare or plan anything as we didn't realise the activity person was off work." Another said, "Hopefully we can do something later, we will put a film on that they like." The registered manager was surprised that staff had not introduced the rummage boxes or books for people. Whilst we acknowledge that the lack of activities was unplanned, the service was not responsive in providing alternatives and did not enough care staff to cover this. This was an area that requires improvement to ensure that peoples' social needs were consistently met.

On the second day of the inspection the care staff organised a craft session and ensured that people were occupied in an activity they wanted to do. We saw people proudly showing their visitors the art work they had produced earlier.

We were told that an activity coordinator was employed to work 25 hours each week and the hours were flexible to meet the needs of people. For example afternoon, weekend or evening entertainers. Visitors and the care staff team spoke highly of the activity coordinator and how she worked with people to ensure that the activities were meaningful for each individual. We were told that each month a new activity programme was drawn up which was varied and included a number of group activities and people had the opportunity to participate or opt out of activities as desired. Activities included musical entertainers, weekly canine concern group, a trip out once a month, shopping, arts and crafts and reminiscence groups. We were also told that there were internet systems for relatives to speak with their loved ones. Staff told us, "The activity person is great We have an activity plan and people are supported and encouraged and it's there if they want to join in." We also saw that consideration was given to people's music and television preferences. We were told that people were encouraged to assist in laying the tables, dusting and have on occasion sorted/folded communal laundry. We saw one staff member encourage and support one person to clear the tables following lunch.

The home encouraged people to maintain relationships with their friends and families. One person said, "I look forward to my family coming to see me. It brightens my day and is important to me." A visitor said, "We are kept up to date with things, always welcomed and feel that our input is important." Another said, "It's a very friendly home, we are treated as part of a big family."

'Service user / relatives' satisfaction surveys' had been completed twice a year. Results of people's feedback was used to make changes and improve the service, for example menu, odours in rooms and choices of food. Resident /family meetings were held and we were also told that people were encouraged to share feedback on a daily basis. One visitor said, "I tell them as it is, they don't mind, very agreeable."

People received care which was personalised to reflect their needs, wishes and aspirations. Care records showed that a detailed assessment had taken place and that people were involved when possible in the initial drawing up of their care plan. They provided detailed information for staff on how to deliver peoples' care. For example, information was found in care plans about personal care and physical well-being, communication, mobility and

Requires improvement

Is the service responsive?

dexterity. Work was being undertaken to improve people's care documentation as some were very basic in detail. For example continence. There was information as to when the pads were to be worn, but no guidance as to people's individual need such checking their levels of comfort or prompting to use bathroom before meals. Staff told us they checked people regularly and if necessary would contact the continence team for further advice. Staff received training in care planning and were gaining experience in writing person specific care plans. The registered manager said she was including care planning in supervision sessions for all staff, new and old.

Daily records provided detailed information for each person, staff could see at a glance, for example how people were feeling and what they had eaten.

Inadequate

Is the service well-led?

Our findings

At the last inspection in November 2014, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were concerns identified within the quality assurance process, such as audits not being acted upon to drive improvement and identify shortfalls in care.

An action plan was submitted by the provider detailing how they would meet their legal requirements by 30 June 2015. Whilst improvements had been made, the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was not fully met. This was a continuing Breach of Regulation 17.

There was a registered manager in post. There had been a deputy manager but she had recently retired. This had caused some delay in completing audits and supervisions but the provider had recruited to the post and the deputy would be in post in January 2016. The manager was viible in the home but admitted that since the deputy had left, there was less time to spend with people and staff. Visitors said that the manager was welcoming and her door was always open. Staff said "The manager is very approachable and is kind and very good with the residents."

Whilst there were some quality assurance systems in place, they were not all completed in full with action plans and had not identified the shortfalls we found. We found that people's safety was potentially at risk from inadequate staffing levels and increased falls. We identified on the first day of the inspection people were unstimulated and isolated at times and that staff did not actively engage with them due to time constraints. There was no system to assess how many staff with the right skills were required at all times to provide people with safe, effective, caring and responsive care. Staff and relatives told us there were not enough staff to meet people's needs. We also found that cleaning audits were not in place to ensure standards of cleanliness were consistently maintained and that environmental audits and feedback from visitors that had identified problems in the communal bathrooms had not been actioned.

Some risk assessments were lacking in specific information to keep people safe and had the potential to cause harm to the individual, such as moving and handling. We also found that people's nutritional needs were not being managed effectively to enjoy the meal time experience or monitored to ensure that people had enough to eat and drink.

Accidents and incidents were documented but lacked follow up preventative measures. The October/November 2015 audit had not identified that 85% of unwitnessed falls occurred in the afternoon and night time and could be a direct result of the reduced staffing levels.

The provider did not have effective systems in place to asses, monitor and improve the quality of the service being provided to people. This was a breach of Regulation 17 (1) (2) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The culture and values of the home were important to the staff team. They were open and honest about the recent decrease of staff on duty. They genuinely felt concerned about increased risk to people. They had written to the provider with their concerns over staffing levels and the recent problem with the equipment used to move people. The provider received the letter on the first day of our inspection. Staff told us, "We work hard to ensure that people receive the care they need, we, as a team are worried that we can't give the quality of care we usually give." Staff we spoke with had an understanding of the vision of the home but from observing staff interactions with people; it was clear the vision of the home had been affected by recent changes to the staff team However staff spoke positively of how they wanted to give the people they supported the care and attention they deserve. Staff said they supported each other, "When it's busy we all get the work done."

Staff meetings had been held regularly over the past year and staff felt meetings were helpful and it was good to discuss training and what was happening within the home with people and staff. For example a new deputy manager. Daily handovers were held at the end of staff shifts and we attended two of them. The quality of the handover was good and gave a good overview of people and any concerns the staff had. The information shared included informed of the status of wounds, blood sugar irregularities and which people had not been drinking and eating enough.

Inadequate

Is the service well-led?

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

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 had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs.**

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 The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks.

The enforcement action we took:
Warning Notice served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place.

The enforcement action we took:
Warning Notice served.