Barchester Healthcare Homes Limited

The Orchard

Inspection report

189 Fairlee Road
Newport
Isle of Wight
PO30 2EP
Tel: 01983 520022
Website: www.barchester.com

Date of inspection visit: 10 and 14 December 2015
Date of publication: 25/01/2016

Ratings

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

Overall summary

This inspection took place on 10 and 14 December 2015 and was unannounced. The home provides accommodation, nursing and personal care for up to 60 people, including people living with dementia. There were 54 people living at the home when we visited.

After the comprehensive inspection in June 2015, we identified that improvements were required to ensure people received a safe, effective service. We received action plans from the provider stating what they would do to meet the legal requirements in relation to improving their service. At this inspection we found improvements had been made but these need time to become sustained and fully embedded in practise.

The home did not have 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.

Summary of findings

The provider had arranged for an operations support manager to take over running the home until a suitable manager could be appointed. The operations manager had applied to the commission to become the registered manager although their appointment was not intended to be long term. They told us a permanent manager had been appointed who would commence employment in January 2016.

The manager had notified us of medicines errors which they were investigating.

People felt safe and staff knew how to identify, prevent and report abuse. People and relatives were positive about the service they received. They praised the staff and care provided. People were also positive about meals and the support they received to ensure they had a nutritious diet. A range of daily activities were offered with people able to choose to attend or not.

Legislation designed to protect people's legal rights was followed. People's ability to make decisions had been recorded appropriately, in a way that showed the principles of the Mental Capacity Act (MCA) had been complied with. Where people had been assessed as lacking capacity, best interest decisions about some elements of their care had been made. These included the use of bed rails and covert (hidden in food) medicines. Other aspects of care which the person may have lacked capacity to consent to had not been assessed.

Staff offered people choices and respected their decisions appropriately.

The Deprivation of Liberty Safeguards (DoLS) were applied correctly. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs. People had access to healthcare services and were referred to doctors and specialists when needed. Reviews of care involving people or relatives (where people lacked capacity) were conducted regularly.

There were enough staff to meet people's needs. The recruitment process was safe and helped ensure staff were suitable for their role. Staff received appropriate training and were supported through the use of one to one supervision and appraisals.

People and relatives were able to complain or raise issues on a formal and informal basis with the manager and were confident these would be resolved. There was an open culture within the home. Visitors were welcomed and had been kept fully informed about the previous inspection and the action that was being taken to address the concerns identified. Staff worked well together which created a relaxed and happy atmosphere, which was reflected in people's care.

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?

Requires improvement

The service was not always safe.

Staff were aware of how to respond in emergency situations however single use suction tubes were out of date and therefore should not be used. People told us they felt safe and staff knew how to identify and report abuse.

The manager had notified us of medicines errors which they were investigating.

Individual and environmental risks were managed appropriately.

There were enough staff to meet people's needs at all times and the process used to recruit staff was robust and helped ensure staff were suitable for their role.

Is the service effective?

Requires improvement

The service was not always effective.

Where people had been assessed as lacking capacity, best interest decisions about some elements of their care had been made. Other aspects of care which the person may have lacked capacity to consent to had not been assessed. This included personal care and medicines for people who may have been unable to understand and consent to the treatment they were receiving.

Staff were suitably trained and supported in their roles. People received effective care and support. They were also supported to access healthcare when required.

People received a varied and nutritious diet together with appropriate support to eat and drink.

Is the service caring?

Good

The service was caring

People were cared for with kindness and treated with consideration. Staff understood people's needs and knew their preferences, likes and dislikes.

People (and their families where appropriate) were involved in assessing and planning the care and support they received.

Summary of findings

People's privacy and dignity were protected and confidential information was kept securely.

Is the service responsive?
The service was not always responsive.

Care plans provided detailed individual information to guide staff although some further improvements were needed to remove inconsistencies within care plans.

People received personalised care from staff who understood and were able to meet their needs. People had access to a wide range of activities.

The manager sought and acted on feedback from people. An effective complaints procedure was in place.

Requires improvement

Is the service well-led?
The service was not always well-led

Improvements to the service had been made which need to be sustained and fully embedded in the day to day running of the home. A permanent manager was due to commence employment in January 2016.

Quality assurance systems were in place using formal audits and regular contact by the provider's area and senior manager and the manager with people, relatives and staff.

There was an open and transparent culture within the home. The provider sought feedback from people and staff; they used the information to improve the home.

Requires improvement

The Orchard

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 10 and 14 December 2015 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor in the care of older people.

Before the inspection we reviewed information we held about the home including previous inspection reports, action plans submitted by the home and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 10 people living at the home and seven family members. We also spoke with the area manager, home manager, 13 nursing or care staff, the activities coordinator, administration staff, the cook and maintenance staff. We looked at care plans and associated records for nine people, staff duty records, four staff recruitment records, training files, records of accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During the inspection we spoke with a health care professional who had regular contact with the home.

Requires improvement

Is the service safe?

Our findings

At our last inspection in June 2015 we found the service was in breach of regulations relating to the safety of people. The provider had failed to ensure that appropriate action was taken when incidents occurred between people and allegations of abuse made by people were not investigated. Medicines were not all administered safely and there were not always enough staff to meet people's needs. The provider sent us an action plan which stated they were addressing the concerns. At this inspection we found that improvements had been made as detailed by the provider in their action plan.

One person told us, "I have no worries at all; I feel perfectly safe here". Another person said, "there is certainly no ill-treatment here". A third person told us "I like it here; it's lovely", "they give me a bath, there is a special chair. I feel perfectly safe in that, it has a foam seat and they lower me down". Visitors also said they felt their family members were safe. One visitor said, "if I felt there was anything wrong here I wouldn't have let [my relative] stay". Nobody we spoke with expressed any concerns about their safety or the safety of their relatives living at The Orchard.

Equipment required to keep people safe was in place. However, staff were unsure how to operate some emergency equipment they told us "we got a new suction unit yesterday; I'm not sure how to work it yet". We looked at the emergency equipment and saw that the single use suction tubes were out of date and therefore should not be used. In another part of the home equipment was in date and located close by a person who may require this. All nursing staff had undertaken first aid and emergency resuscitation training including the use of the defibrillator.

The manager had notified us of medicines errors which they were investigating. Medicines were administered by qualified nurses who had been assessed as competent to administer medicines. Staff administered medicines competently, explaining what the medicines were for and did not hurry people. Most Medicine Administration Records (MARs) were fully completed. We found three MARs where there were gaps which did not show if medicines had been administered. Stock levels were checked and indicated that this was a recording error and people had received their medicines as prescribed. Staff undertook a weekly medicines audit to ensure the balance of medicines was correct and that people had received medicines as prescribed and recorded on MARs.

Where people had been prescribed 'as required' (PRN) medicines, they had a PRN plan which explained when the medicine could be given. Staff were aware of how and when to administer medicines to be given on a PRN basis for pain or to relieve anxiety or agitation. There were suitable systems in place to ensure prescribed topical creams and ointments were applied correctly. This included body charts to identify where specific creams should be applied and records completed by care staff to confirm application. Topical creams had an 'opened on' date which would help ensure these were not used beyond the safe to use date. All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. There were effective processes for the ordering and checking stock into the home to ensure the medicines provided for people were correct.

The provider had appropriate policies in place to protect people from abuse. Staff had received training in safeguarding adults and were aware of how to safeguard people in their care. They knew what signs to look for which could indicate that the person was being harmed in some way. This included physical, emotional and behavioural signs. Staff took personal responsibility for people's safety and were clear and confident about the process to follow if they had concerns. They were aware of how to escalate their concerns if appropriate action was not taken in a timely manner. They said, "I would always 100% take it to the area manager if I had to; it's a horrible situation and I have never had to do it, but I would if I needed to". We saw notices around the home reminding staff who and how to contact external professionals and organisations if they were concerned about abuse or the safety of people. Staff said they documented any unexplained bruising they noticed on people and completed incident forms to record this and enable the manager to analyse incidents each month.

The manager was aware of safeguarding and what action they should take if they had any concerns or concerns were passed to them. They described the action they had taken following a recent safeguarding concern which helped to ensure the safety of the person and other people. When

Requires improvement

Is the service safe?

there had been disagreements between people living with dementia, appropriate action was taken. Systems were in place to protect people from the risk of financial abuse. All valuables and personal property were documented on admission to the home. Any transactions made on behalf of people were documented in invoices.

Risks were managed safely. A person who was cared for in bed related how they were not able to sit up unaided. They said staff came to them and always made sure they was sitting upright before they were given their meals. Another person cared for in bed said staff cut their food up so they could eat it safely. Staff were aware of the risks to each person and how to keep them safe, for example, ensuring that a person who was at risk of falling out of bed had bed sides in place.

All care plans included risk assessments which were relevant to the person and specified actions required to reduce the risk. These included the risk of people falling, nutrition, choking, moving and handling and developing pressure injuries. Risk assessments had been regularly reviewed and were individualised to each person. These procedures helped ensure people were safe from avoidable harm. Where people had fallen, comprehensive assessments were completed of all known risk factors and additional measures put in place to protect them where necessary. Discussions with the manager showed they considered all possible causes of falls and medical advice was sought when necessary. Staff had been trained to support people to move safely and we observed equipment, such as hoists and standing aids being used in accordance with best practice guidance.

Environmental risks were assessed and managed appropriately. The home's security measures, which included keypad coded doors, were secure at all times. Records of maintenance checks by internal staff and external contractors showed these had been completed as required. A fire evacuation plan was in place. This covered the evacuation equipment required, if the person had complex needs, such as dementia or behaviour that could put themselves or others at risk. Also included was information about support needed with mobility and if the person would be in imminent danger due to their proximity to an oxygen supply. All staff knew the procedures to follow if the fire alarm sounded and confirmed they had received fire awareness training.

There were enough staff to meet people's needs at all times. People were positive about staff. A relative said that their family member, who required significant staff support always had staff with them when they visited. They said that they were always asked if they wanted the member of staff to stay before they left the person alone with their relative. Visitors said staffing levels had improved greatly since the last inspection, especially at the weekend. One said now, "there are just as many staff at the weekend as there are during the week". They added that there were always senior staff to talk to if needed. Staff were organised, they told us they were allocated to specific areas of the home and assigned named people to care for each day. Call bells were responded to quickly throughout the inspection. One person said, "If I press the bell they come pretty quickly, and at night, also pretty good." Staff told us they had enough time to meet people's needs. We observed staff had time to sit and talk with people and did not rush them when providing care or support in communal areas. Staff absence and sickness was covered by permanent staff working additional hours meaning people were cared for by staff who knew them and understood their needs.

Staff recruitment processes were safe. Staff applying to work in the home were subject to an interview which covered their skills, knowledge and suitability to work with people living in the home. Checks were made as to their medical fitness to work, and conduct in previous employment and criminal record checks with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Requires improvement

Is the service effective?

Our findings

At our last inspection in June 2015 we found the service was in breach of regulations relating to the provision of an effective service. Where people lacked the capacity to make decisions themselves legislation designed to protect their rights was not always correctly used. We also found that action had not always been taken to ensure people's health needs were fully met and staff were not receiving appropriate support. The provider sent us an action plan which stated they were addressing the concerns.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). 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 made on their behalf must be in their best interests and as least restrictive as possible. Staff told us, "residents have the legal right to make their own decisions about things in their lives and we always assume people have capacity to make these decisions unless there is contrary proof". Another said "we have had a lot of training on mental capacity and we all know that every resident, unless they have had an assessment that says they do not have capacity, always have the mental capacity to make the decisions that affect their lives for as long as they are able". Where people had been assessed as lacking capacity, best interest decisions about elements of their care had been made and documented, following consultation with family members and other professionals. These included the use of bed rails and covert (hidden in food) medicines. However, other aspects of care which the person may have lacked capacity to consent to had not been assessed. This included personal care and medicines for people who may have been unable to understand and consent to the treatment they were receiving.

Care plans contained information stating relatives or others had legal powers to make decisions on behalf of people in respect of their health or finances. For example, one person's care plan stated that their relatives had lasting power of attorney for health decisions. The manager had not sought clarification of this such as obtaining copies of the legal documents giving the relatives these legal rights. This meant they could not be sure who could legally make decisions on behalf of people.

Staff showed an understanding of consent. Before providing care, they sought consent from people using simple questions and gave them time to respond. One staff member said, "if they don't want to get out of their pyjamas all day then that's fine". They said that if a person refused personal care, or their meal, they would try to persuade them, or come back a little later to see if the person would accept the care then.

The provider had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). 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 and hospitals 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. Staff were able to give clear accounts of the meaning of DoLS and how these might affect people in their care. Where necessary applications had been made to the local authority for an assessment under the DoLS legislation.

People and relatives were happy with the care they received. People said they were seen by a GP when they were unwell, but they called the nurses first. One person said, "The doctor comes here once a week I think, if you need him. You can ask for the nurse if you need help". Another person said, "A woman comes and does my feet". A relative said their family member's health was monitored and they were referred to a GP if necessary. We observed staff taking care about a person's health. They had become a little faint after, "rushing down the hallway". Staff got a chair for the person, and a drink and stayed with them until they started to feel a little better. The Nurse asked staff to take the person's blood pressure and pulse, "to just check they are all OK".

The manager told us they were working with the local GP surgeries to provide an improved service for people. One surgery was becoming the lead surgery for the home with the majority of people transferring to that surgery unless they wished to remain with their existing GP. This would mean GP's could provide a more regular service to the

Is the service effective?

home and not just respond to ad hoc call out requests. We spoke with a GP who told us they felt this would save GP's time but also provide an improved service for people at The Orchard. Care records showed people were referred to GPs, and other specialists when changes in their health were identified.

People and relatives were positive about the staff. A relative said, "staff are good at what they do". Adding, "they are skilled but I think they have ongoing training as well". Staff were knowledgeable about the needs of people and how to care for them effectively. All staff, including catering and housekeeping staff undertook an induction which included essential training. New care staff received induction training which followed the Care Certificate. This sets the standards people working in adult social care need to meet before they can safely work unsupervised.

Records showed staff were up to date with essential training and this was refreshed regularly. The home's trainer kept records of the training staff had completed and what training they needed to refresh. Staff training records showed all training was up to date, and where training was about to go out of date, or was by a couple of days, the trainer was aware and had posted training update arrangements for staff. Following training, each member of staff completed a knowledge check questionnaire to show they had completely understood all aspects of the training. The trainer said they had recently introduced observations of staff practice following training to ensure the training was applied by staff in practice. This was ongoing and records were kept of the observations.

A member of staff had just completed training in the care of people's skin. They were able to relate what signs they would look for when providing personal care for people and what action they would take to ensure people's skin was cared for appropriately. Staff told us about dementia training they had recently completed. They said this "helped me to be more aware of how they may be thinking". Nurses were able to extend their clinical skills. One said they had recently completed training to take blood samples. They said, "I go to all the training, every course I can; I've learned so much here, even though I am a registered nurse, especially about people with dementia".

Staff were supported appropriately. They received one-to-one sessions of supervision approximately every two months and a yearly appraisal. This was a formal process which provided opportunities for staff to discuss their performance, development and training needs. Staff files showed they received supervision regularly. These were documented with the aim of the discussion and the outcome of it. They covered staff training needs and future development goals, their progression and any issues they may have about their work. Staff had signed the supervision to indicate their agreement with the record.

People said they enjoyed the food provided. They commented, "The food is nice; I'm having lamb stew today, there was something else, it was cheesy and I don't like cheesy things. Then there's spotty dick; I like it; it's quite nice and the chef is nice, you can't fault him. I had toast for breakfast but you can have poached eggs, whatever you like". Another person said, "some things I really love; others are not how you would cook them yourself, but I have no complaints. They ask me what I want for breakfast, "do you want egg and bacon" but I have never had that as a routine, so once a week is enough for me. I have cornflakes in hot milk and definitely no sugar. If I wanted egg and bacon I would definitely be given it". People were offered varied and nutritious meals which were freshly prepared at the home prior to each meal. Alternatives were offered if people did not like the menu options of the day. For example, we saw a person helping themselves to a banana and a person who was eating a lunch meal which was not seen on the main menu.

People received appropriate support to eat and drink enough. Staff offered drinks frequently, and people in their bedrooms had drinks in front of them. Drinks were available throughout the day and staff prompted people to drink often. People were encouraged to eat in the dining rooms making mealtimes a pleasant and sociable experience. Brightly coloured crockery was used which helped make food look more attractive to people living with dementia, and encouraged them to eat well. People were encouraged to eat and staff provided appropriate support where needed, for example, by offering to help people cut up their food. On the first day of the inspection arrangements in the dining room in one part of the home were chaotic with people waiting a long time for their meals. This lead to some people getting up and walking around or leaving the dining area and people receiving support from several staff at different times. On the second day of the inspection, the dining room was more organised and continuous support was provided to individual people by one staff member. Special diets were available for people who required them. Catering staff were aware of

Requires improvement

Is the service effective?

people's special dietary needs and described how they would meet these. Staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration. They monitored the weight of people each month or more frequently if required due to concerns about low weight or weight loss.

The environment was appropriate for the care of older people with specific adaptations such as a passenger lift to the first floor and hand rails around the home. We saw the building had been decorated taking account of research to support people living with dementia or poor vision to find their way around. This included brightly coloured doors to bathrooms and toilets and hand rails of contrasting colours to walls. Accessories had been used to create pleasant and varied places to sit such as an internal garden area. People on the ground floor had access to the gardens which were fully enclosed and provided various seating options. We were told staff had taken people from the first floor outside during the summer.

Good

Is the service caring?

Our findings

At our last inspection in June 2015 we found the service was not always caring. People's dignity had not always been ensured by some care practices in the home. People were not always supported to express their views or actively involved in making choices about their care, treatment and support. The provider sent us an action plan which stated they were addressing the concerns.

People's care plans had been reviewed and now contained more individual information. The person, or someone who knew them well, had been involved in identifying how the person should be cared for. People's preferences, likes and dislikes were known, support was provided in accordance with people's wishes and staff used people's preferred names.

Staff understood people's individual needs and supported people to be as independent as possible. One person told us, "I do my own bed; I am independent like that". A staff member said, "I look in their care plan to see what they can and can't do for themselves. It's important because we don't want to take away their independence". Another said, "I ask them what they want to do for themselves, and we go from there". Staff were aware of the contents of care plans and as a consequence they had knowledge of people as individuals. At meal times we saw staff were available to support people but did not take over.

People were cared for with kindness and compassion. One person said, "All the staff are very caring". Another person said, "they take notice of you here. I have my own room, my own things. Staff are very respectful." A person cared for in bed said the staff attitude was, "pretty good; kind and gentle when they help me shift position in my bed". They added that when they get washed in bed staff were respectful. A visitor said, "I cannot fault the care; the attention [my relative] gets is good". They added, "the staff are very respectful, without a shadow of a doubt. They are treated as their own parents or grandparents". A relative said, "the staff take time to know us as visitors", and "the level of interaction between staff and people in the (dementia) unit is really there now, where it was lacking before". Another visitor said, "all the staff are kind, caring and helpful".

There was a considerable amount of warm and friendly exchanges between staff and people which were, when people were able, reciprocated in the same way. Staff spoke fondly of the people they cared for which indicated that they held them in high regard. Staff spoke with people while they were providing support in ways that were respectful and we also found this respect in the way that records were made about people. Staff addressed people by name, and in an appropriate manner, such as getting down to the level of a person sitting and speaking closely to the ear of someone who was hard of hearing. One person was distressed because they needed to talk with a member of their family and had not been able to contact them. A staff member spoke kindly to them, reassuring them that they would make every effort to contact the family member on their behalf that day. Later, the member of staff came to the person and told them they had been able to make the call and gave the person the news they were waiting for. The news was delivered in a tender manner and support and comfort was given to the person when they became emotional.

Staff supporting people were patient and attentive. A person was not communicating verbally in a way that could be understood but the member of staff supporting them responded to the noises they were making in a positive and calm tone. The member of staff held the person's hand when they reached out. They noticed their hand was a little cold and asked them if they would like another blanket. When a person had a coughing episode the member of staff showed care saying, "it's OK, that's it, you've got it; do you need to cough a little more? there we are, you're OK now". They then got a cushion and helped the person sit a little farther forward to ease their swallowing. When another person called out to the staff member saying, "excuse me, do I pay now?" the staff responded, "you don't need to pay, it's all paid for today". The person expressed their concern, saying, "what about the chef?" to which the staff responded, "that's OK, the chef is feeling generous today". The person was reassured and went on their way. We saw staff had a good approach with people who were not responding to their requests if they wanted to eat something. Staff left the person a little while and another member of staff would try, often with success.

Although the staff were busy they behaved in a warm and caring manner towards people. We saw staff took time to take a person accommodated in one area of the home to spend some time with their husband who was living in another part of the home. Staff used terms such as "sweetheart" and "darling" fairly often which people

Good

Is the service caring?

responded to warmly. Staff were observed comforting people who had become upset, with reassuring words and appropriate physical contact. We saw several examples of caring and kind moving and handling, with a lot of patience and concern about the person and their mood and feelings at the time. On two occasions we saw two different people break out into song whilst being wheeled in a chair by staff. The staff member spontaneously joined them in singing.

People's privacy and confidentiality were protected. One person told us, "I can go to my room whenever I want". A person who was cared for in bed said they, "had no problems" in relation to their dignity when being given personal care. Another person said. "A fella [male care staff member] helps me have a bath; you can choose who you want [to support you]; I don't mind". Staff took care to talk to people in a discreet manner about their personal needs. They shut doors and talked in low tones to each other about people's needs and how to meet them. They described how they would cover people, with a towel or a sheet, when providing personal care, ensuring they were not exposed for any longer than they needed to be saying, "I reassure them and talk to them saying "I won't be long". When people required personal care staff spoke with them quietly and then supported them to their rooms. We saw one person who had been incontinent. This was quickly noticed by a member of care staff. They spoke with them and then escorted them discretely to their bedroom which meant the care they required was provided in a way that protected their privacy and dignity. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view them.

Some staff were designated as dignity champions. These staff promoted dignity in the home and engaged with other staff about how to preserve people's dignity. For example, by paying specific attention to people's personal appearance and hygiene where people were unable to care for this themselves. The dignity champions had identified specific areas which could affect dignity to be focused on in the coming months.

Requires improvement

Is the service responsive?

Our findings

At our last inspection in June 2015 we found the service was in breach of regulations relating to the provision of a responsive service. People had not always received the correct healthcare and health monitoring they required. Action had not been consistently taken following falls, there was a lack of activities and complaints were not investigated in a timely manner. The provider sent us an action plan which stated they were addressing the concerns.

People received personalised care from staff who supported them to make choices and were responsive to their needs. People commented, "they do exactly what I want them to do for me". I decide when I get up and when I go to bed". Sometimes they say, "would you like to go to bed just now" and I say, "no, a bit later", and they go away and come back later when I am ready"; "I like my room. Recently they changed the layout for me, as I was in a bit of a draught. Now I can see the telly ok, it doesn't disturb anyone else and there is no draught. I am better off now"; "I can stay in bed until whenever I want to, but I like to get up early". A relative said, "they have really responded to [my relative's] decline in health. They are aware of the fact that he can wander and they always know where he is." They added that staff knew the details about their relative, such as how he liked his tea.

A member of staff, "You get to know people's likes and dislikes", and then told how the person they were caring for that morning did not like being around a lot of people. We observed that they had been seated at a table with the care staff and no other people as this may have caused them distress. A member of staff providing 1:1 care for a person who had limited verbal communication showed how they respected the person's choices. They offered both puddings, and the person was able to indicate which one they would like.

People were involved in discussions about their care and how it should be provided. One person recalled their care being reviewed with them. They said, "they ask me if I am happy with everything and they write it down on a sheet of paper". A relative said they were fully involved with the care of their family member, any changes in medication or their health was informed to them. They also said staff were honest with them about their relatives future care needs. The relative said periodic reviews were held with them about every six months. They said this was an hour or more in length and therefore they were not rushed and had time to discuss anything they wished. They added, "It isn't a quick chat; they book an appointment with us".

Care records had been updated since our previous inspection in June 2015. They had also been reviewed and evaluated monthly. These provided comprehensive information although we found some minor discrepancies in care plans where information in one part was at odds with information in another section. We also identified some additional care plans which were required such as for a person who had epilepsy. A nurse said, "Yes you are right there is not one there but they have not had a seizure for years but I agree we should have one and I will do one today". They started working on this before our inspection was completed. There were also some small aspects of people's records which could have been more specific. For example, a care plan stated a person could become agitated during personal care and stated "can be very agitated. Give plenty of reassurance". There was no specific guidance about what this meant and the way reassurance should be provided. Similar comments about providing reassurance without individual specifics were found in several other care plans.

Individual care plans were well organised and followed by staff. For example, when people had been identified as being at risk of skin damage, a pressure risk assessment was completed and a care plan produced which responded to the degree of risk identified. There was a range of pressure relieving devices that would help to reduce pressure on people's skin and corresponded to the guidance in the person's care plan. Records of repositioning showed people were receiving the necessary care to help prevent deterioration in their skin condition.

Staff said they used people's care plans to find out what their needs were and also what their background was. They said this helped them get to know people better and form relationships with them. Staff were able to describe the care provided to individual people and were aware of what was important to the person in the way they were cared for. They gave an example of how a person they cared for used to be a hairdresser. Their care plan noted this and that the person liked to do their own hair, and staff were not to touch it. Records of daily care confirmed people had received care in a personalised way in accordance with their care plans, individual needs and wishes. Reviews of

Is the service responsive?

care were conducted regularly by allocated nurses. As people's needs changed, care plans were developed to ensure they remained up to date and reflected people's current needs. All staff received a formal handover sheet at the start of each shift. We saw that this provided a range of important information for staff and space for any special instructions for staff such as anyone who required their weight to be checked or urine samples taken. The use of a formal handover sheet meant all staff received consistent information which they could refer to as they supported people.

Nursing and care staff recorded the care provided to people in daily records in care files. They also recorded some information in handover books. We saw that information from handover books was not always then recorded into care files. For example, one person was at risk of weight loss and was being weighed weekly. The records in their care file suggested this was not being done. However, we saw in the handover file that their weight was recorded. The failure to transfer this information to the person's weight record in their care file meant the weight loss was not being noted on a regular basis and could mean action to respond to weight loss could be delayed. Nursing staff had not recorded all contact with medical staff. For example, we were unable to clarify what action had been taken in response to a request for blood tests for a person to check if they were receiving the correct amount of a medicine. Records of food and fluids people received were improved but there were some gaps where it was not clear if the person had received a meal or drinks.

People were offered a range of activities suited to their individual needs and interests. The activities staff member said they varied activities to match people's interests and abilities and they had suitable equipment to meet most needs. A relative said staff had researched what their family member had been interested in when they were younger, and had sourced information about their interests and shared this with the person during 1:1 activities. They said, "he is most certainly cared for as an individual". And added that despite the person's deterioration in ability to engage in activities, staff met his needs and ensured he was able to walk around the home and observe things going on. One person said, "They do lots of things but I don't join in; that's my choice". They were later observed to be enjoying the carol singing. Another person said, "I go down to the games occasionally but they are bit boring. I like quizzes and things like that".

The interests, hobbies and backgrounds of people were recorded in their care plans. This provided staff with information about topics the person may like to talk about or be interested in. The manager told us the provider had agreed for a second full time activities staff member to be appointed. This meant that activities would then be provided seven days a week with three days having two activities staff. There was a planned programme of external entertainment coming into the home.

People were given opportunities to express their views about the service. Meetings with people and their families took place regularly. Minutes were seen which showed topics identified by people and relatives were discussed and action taken where necessary. Relatives told us they received postal reviews from Barchester to complete. Relatives were clearly aware of who the manager was and stated the manager was very approachable. The manager held a weekly "surgery" providing an opportunity for people or relatives to discuss anything with them. They said they made a point of talking to people and visitors and felt this meant any issues could be raised in an informal way which could be quickly resolved. A suggestions box was available providing opportunities for anyone to make anonymous compliments, suggestions or complaints should they wish to do so.

People knew how to complain or make comments about the service and the complaints procedure was displayed on the notice board in the entrance hall. One person said they had a complaint which they had spoken with the manager about "a thousand times". The manager explained that a plan had been produced with the person's input and which had been agreed with all parties. They reassured the person that they would talk with relevant staff to remind them of the agreement. A relative said they had their concerns attended to very quickly. They had no serious complaints but when they mentioned anything it was soon sorted out. They said they were asked verbally every time they visited if they were happy with the way their relative was cared for, "it is part and parcel of how they care for him".

The complaints records showed that five complaints had been made since the previous inspection. Some related to issues from before the previous inspection. All had been investigated comprehensively and complainants were responded to in writing.

Requires improvement

Is the service well-led?

Our findings

At our last inspection in June 2015 we found the service was in breach of regulations and was not well led. Quality monitoring systems had not ensured people received a safe and effective service. Systems in place to monitor and respond to complaints, incidents and accidents had not been followed. The provider had not notified the CQC of significant incidents in the home as they were required to do. The provider sent us an action plan which stated they were addressing the concerns.

At this inspection we found that the issues identified at the inspection in June 2015 had been addressed and action had been taken to become compliant with all regulations. The improvements and systems to monitor and review the quality of care still need time to become embedded and sustained in practise. For example, there remained some inconsistencies within care plans. A temporary manager had been appointed who was in the process of registering with the commission to become the home's 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. The temporary manager informed us a permanent manager had been appointed who would be commencing employment in January 2016.

A relative said, "Initially we had some problems with information not being passed on; from what I have seen they made quite a few steps towards remedying that; we are made aware of things now, and we are consulted". They added that the home, "now has leadership" and that the manager is always available to speak with, even at the weekends. They continued, "the last inspection was a real shock, but it was the kick up the backside that they needed here. The relaxed management was a problem. It really shows now they have an experienced manager in place".

Staff were also positive about the changes in the management. One staff member told us, "[the manager] has made such a difference; we all feel this, we now have a great leader who is open and friendly but also knows what they are doing, it is great to have such a good manager". Another staff member said, "things are really different here now, it has changed since the new manager came here, she really knows her stuff, she communicates really well, no secrets and she is always around, you see her all the time and that makes a difference too". Another staff member said that the manager had, "been brilliant" when they had a period of ill-health. A nurse said they felt well supported in their role saying about the manager, "now I have someone I can go to". A newer member of staff said there was good teamwork saying, "the staff here have been absolutely brilliant".

There was an open and transparent culture within the home. The manager had been open with people, relatives and staff about the issues and concerns identified during the inspection in June 2015. A copy of the report following that inspection was available for anyone in the entrance lobby together with the action plan showing what was being done to address the concerns. A relative said that periodic meetings were held with the families. This was an opportunity for family members to express any concerns about the poor inspection rating last time. Action being taken was communicated back to them via an action plan, both verbally and in written form.

The manager was developing links with the local community. We saw photographs and a thankyou letter from the local special care baby unit for the donation of knitted items for premature babies. These had been knitted by people as part of their activities and not only helped the premature babies but provided people with as sense of achievement and self-worth. People were also raising money for the local air ambulance service. The home provided a venue for a monthly Alzheimer's café and a church service which people from the nearby sheltered housing also joined. The manager said they would like to increase links with the local community such as the school located adjacent to the home.

There was a clear management structure in place and all staff understood their roles. The manager did not have a nursing qualification and told us they had access to advice and support from the regional support manager who was a qualified nurse. We saw the regional support manager was present on both days of the inspection. We observed positive, open interactions between the manager, staff, people and relatives who appeared comfortable discussing a wide range of issues in an open and informal way. There

Requires improvement

Is the service well-led?

was a whistle blowing policy in place, which staff were aware of. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations.

Auditing of all aspects of the service, including care planning, medicines, infection control and staff training was conducted regularly and was effective. The provider had a quality assurance and clinical governance system which directed managers as to the areas they should audit throughout the year. Other quality indicators, such as accidents or incidents, could be directly viewed by the provider's senior management team via a shared information technology system. Systems in place meant that any accident or incident reports were seen by the manager. They described how they would discuss these further with nursing or care staff if necessary and ensure risk assessments and care plans were amended.

The manager was aware of key strengths and areas for improvement. We identified minor areas which could improve the service; the manager acknowledged these and suggested appropriate action which they planned to take to address these areas.

The provider had an extensive range of policies and procedures which had been adapted to the home and service provided. We saw these were available for staff in the nurse's offices. Staff referred to these at one point during the inspection showing they were familiar with the procedures file. We were told any new policies were reviewed internally by the manager before being put in place to ensure they reflected the way the home was working. This ensured that staff had access to appropriate and up to date information about how the service should be run.