Care UK Community Partnerships Ltd

Cavell Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Cavell Court provides accommodation, personal and nursing care for up to 80 older people. This comprehensive inspection took place on 12 and 13 November 2018 and the first day of the inspection was unannounced. Cavell Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

Cavell Court accommodates people across three floors, each of which have separate facilities including a dining room and lounge. One of the floors specialises in providing care to people living with dementia and another in nursing care. At the time of this inspection there were 68 people living in the service.

Our last inspection at Cavell Court, in January 2018, was the third inspection since 2017 where we had rated the home Requires Improvement overall. At that inspection we were concerned about the continued lack of effective oversight of the home which meant the necessary improvements had not been made. We therefore rated the service as Inadequate in Well-Led. At that inspection in January 2018 we were also concerned that there continued to be failures with the safe management and administration of medicines which placed people at risk of harm. These concerns had been highlighted in previous inspections and were therefore a repeated breach of the regulations.

Also at our last inspection we found there were insufficient staff to meet people's needs in a timely manner. A lack of staff presence meant that people were not getting the care and support they required. Concerns were also raised with us about how the provider responded to complaints and the high use of agency nurses to deliver people's care which meant that people were not always having their assessed care needs met.

You can read the reports from our previous comprehensive inspections, by selecting the 'all reports' link for Cavell Court on our website at www.cqc.org.uk

The service is required as part of its registration to have a manager registered with the CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a registered manager, who commenced employment shortly after our last inspection, in post at the time of this inspection.

At this inspection a number of improvements had been made. The management of medicines was safer and we were now confident that people were receiving their medicines as the prescriber intended, however we did find that the registered manager and staff had not considered the risk of people living at the service accessing topical creams and causing themselves accidental harm.

Improvements had been made to the staffing levels and these were now sufficient to provide responsive

care to people. Recruitment checks had ensured they were suitable to work with people using this service. Staff were supported through training and supervision to perform their roles effectively. The staff were knowledgeable about the support people required to enjoy their meals and drinks safely and this was provided.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were treated in a kind and caring way by the staff team. Their privacy and dignity was respected. Staff interacted with people in a caring, respectful and professional manner. Staff had developed relationships with people and were attentive to their needs.

The service was now well managed and the provider had invested extensive management time at the service since our last inspection. A new registered manager was now in post and there were effective quality assurance arrangements in place to monitor care and plan ongoing improvements. People's views about the running of the service were sought and changes and improvements took account of people's suggestions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

There were enough staff to meet people's needs in a timely manner.

Robust employment checks were carried out before staff started working at the service.

Improvements were needed to the assessment of risk around storing topical medicines.

Staff knew how to protect people from the risk of harm and how to report any concerns.

Is the service effective?

Good

The service was effective

Staff were suitably trained and had received supervision.

People were supported to eat and drink enough to help keep them as healthy as possible.

People had access to healthcare services.

Staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring

We observed staff speaking with people in a polite and respectful manner.

Staff were kind and compassionate.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive

People participated in a variety of activities according to their interests and wishes.

There was a procedure to record and respond to any concerns or complaints about the service.

People were supported in the way they preferred at the end of their life.

Is the service well-led?

Good

The service was well-led

People, their relatives and staff felt the service was well-led since the current registered manager commenced employment.

Checks completed on the quality of the service had improved and action was taken to remedy any shortfalls.

People, their relatives and staff shared their views and experiences of the service and these were acted on.

Cavell Court

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 13 November 2018 and was unannounced.

The inspection team consisted of three inspectors, a specialist medicines inspector and two experts-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. Before the inspection we reviewed information that we held about the service such as statutory notifications. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

We looked at the care records of seven people in detail to check they were receiving their care as planned. We also looked at records including a staff recruitment file, training records, meeting minutes, medication records and quality assurance records.

Over the two days we visited, we spoke with eleven people who live in the home, five members of care staff, the chef, the life style co-ordinator team leader, two nurses, the clinical lead, two team leaders, the deputy manager, the quality development manager, the regional director, an operations support manager and the registered manager. We also spoke with relatives of eleven people currently living in the home and another visitor. Following our visit, a further five relatives contacted us to share their feedback.

Good

Is the service safe?

Our findings

At our last comprehensive inspection in January 2018 we rated this key question 'Requires Improvement' and found a breach of Regulations 12 and 18 of the HSCA RA Regulations 2014. We had concerns that people did not always receive their medicines safely or as prescribed. We also found at that inspection that there were not always sufficient staff with the required skills to meet people's needs. At our last inspection staff were not always aware of the risks to people from receiving care and support and any actions put in place to mitigate risk were not always carried out. At this inspection we found improvements had been made. After having concerns about the safe management of medicines at our previous inspection at this inspection the necessary improvements had mostly been made.

At this inspection in November 2018 a member of the CQC medicines team looked at how the service managed people's medicines and how information in medication records and care notes supported the safe handling of their medicines.

The provider had recently put in place an electronic system to manage and record people's medicines. Records on the system showed people had received their medicines as prescribed. There were internal audits in place to monitor medicines and their records and for staff to take action when issues were identified.

Oral medicines were stored securely for the protection of people who used the service and at correct temperatures. However, we noted medicines prescribed for external application such as topical creams were not secured. The registered manager and staff had not considered the risks about people living at the service accessing these medicines and causing themselves accidental harm. We spoke to the registered manager about this who had begun devising risk assessments in this area by the second day of our visit.

Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification and information about known allergies and medicine sensitivities and information about how people preferred to have their medicines given to them. When people were prescribed medicines on a when-required basis, there was written information available to show staff how and when to give them to people to ensure they were given consistently and appropriately. There were additional records in place, for example, to ensure safety for people prescribed medicated skin patches.

For people with limited mental capacity to make decisions about their care or treatment and who would otherwise refuse their medicines, the service had consulted with and obtained written guidance from their relatives, GPs, and pharmacist about how to give the person their medicines crushed and hidden in food or drink (covertly).

At our last inspection we were concerned that staffing levels were not sufficient to meet people's needs. People, their relatives and staff told us there were insufficient staff to meet people's care needs in a timely manner. At this inspection we found that improvements had been made to the staffing levels at the home and that there had been a reduction in the use of agency staff. Through targeted recruitment, the registered

manager had managed to significantly reduce the amount of agency care and nursing staff and increase the levels of permanent staff. In addition, the numbers of staff on shift had also been increased since we last inspected.

At his inspection the majority of people we spoke with told us there were sufficient staffing levels to meet their needs in a timely manner. One person said, "Yes I think there are [enough staff]. When I sit here [bedroom] I have the door open and the staff are always up and down the corridor." Another person said, "Oh I think so. There's always staff around." A third person however said, "I don't think they can get the staff, they are short of [staff] all the time and it's most obvious in the morning and at meal times. If you ring your bell then, there can be a wait of up to half an hour." And a fourth, "They [staff] are busy in the morning when they're getting [people] out of bed and at lunch and dinner time it's busy too but even then, if I need help and ring my bell, they come within five minutes, 10 minutes would be unusual."

A relative told us that they had had concerns about staffing levels in the past. They described how they and another visitor to the service had, in the past, felt they needed to 'roll up their sleeves' and help people at a mealtime, because there were not enough staff. They said however that staffing levels were now much better, including at weekends and that where there were agency staff on shift, they were usually regular workers who knew people well.

During our inspection visits, staff responded to call bells promptly, despite there being staff sickness and two staff less than planned during our first visit day. Most staff spoken to confirmed that they were busy but told us that they did not feel staffing levels were unsafe. One member of staff told us, "Staffing levels are a lot better, the new [registered] manager has improved things; better structure and routine." Another member of staff said, "Staff levels are generally good but some days are busy if staff are absent."

Whilst visiting a person in their bedroom we inadvertently stepped on a pressure mat on their floor. The pressure mat was designed to let staff know when a person was up and moving so they could attend and ensure their safety in mobilising. After we had set the pressure mat alarm off, a member of care staff arrived within two minutes and reset the alarm. They also quickly noticed the persons call bell was out of reach and moved it across the bed so it was within reach of them and told the person where they had moved it to. This helped to confirm that there were enough staff to respond to people's needs in a timely manner.

The registered manager told us the staffing levels were not only based on people' dependencies and the tool used to assess this but that she also carried out visual observations of care in practice to ensure staffing levels were adequate. The registered manager told us, "I work 'out on the floor' and listen to the feedback from staff. It was clear we needed additional staff which we now have." We saw records that demonstrated the dependency tool and records were updated as people's needs changed.

A staff member recruited recently, told us about the process they underwent. This included checking their full employment history and taking up references. They said that they also could not start work until the registered manager received an enhanced disclosure from the Disclosure and barring service (DBS). DBS disclosures provide information about the background of applicants, any criminal records they have and whether they have been barred from working in care services. They assist managers of care services to make safer recruitment decisions. The recruitment practices used contributed to safeguarding people living in the home. We also checked a staff record to confirm this practice.

People told us they felt safe living at Cavell Court. One person commented, "Yes I do [feel safe]. I'm safe as long as I do as I'm told and not try to move around without my frame!" Another person said, "I have to use my frame, then I'm okay. I can go downstairs or stay up here, I do what I want."

People were supported by staff who recognised the signs of potential abuse and harm and how to escalate these concerns should they have occurred. Staff had received training in protecting people from the risk of abuse and staff we spoke with had a good knowledge of how to recognise the signs that a person may be at risk of harm. These staff knew how to escalate concerns to the registered manager or to external organisations such as the local authority.

A relative told us how much they felt the service had improved since the last inspection. They told us that they had travelled considerable distances to visit each day because they were worried about standards of care. They went on to explain to us how much they felt things had improved. They told us they had felt confident to go on holiday during the summer and now came to visit twice a week rather than every day. They told us, "I've got peace of mind now. [Person] is safe and cared for."

During the course of our inspection, we queried an injury to one person that was not clearly accounted for in their records. The management team followed this up and the person was clear that they had not experienced any rough handling or unpleasant treatment from staff. We concluded following discussion and their follow up that it was a recording shortfall in explaining what had happened. The recent history of the service showed that the management team reported concerns to the local safeguarding team promptly, and took their advice about any actions required.

People's care records contained information about the risks to which they were exposed. This included risks associated with mobility, from falls – including the use of bed rails, choking, not eating or drinking enough and to people's skin integrity. We saw that staff reviewed the information regularly to make sure that it reflected current risks to people's safety and how they were managed.

For another person, a recent decline in their health and wellbeing increased the level of risk that their skin would break down. This was because they were unwell and no longer able or willing to change position for themselves. On the first of our inspection visits, an update to their records showed that they were to be nursed on an "air flow" mattress to relieve pressure and reduce risk. This equipment was arranged and put in place during the afternoon. This contributed to promoting the person's safety. The person had insight into their condition and the capacity to refuse or accept staff assistance. Staff recorded when the person had declined their support.

We noted that there was an oversight in completing an accident or incident record for this person during the day before our inspection started. Staff had not made the management team aware of it so they could follow up but they acted to review circumstances as soon as we raised the issue.

Infection control practice was good on the two days of our visit. We saw staff wore gloves and aprons and used hand gels before delivering personal care. This protected both people and staff from potential cross infection. An infection control audit was completed to identify if standards were not being maintained and housekeeping staff had team meetings to review cleanliness and hygiene practices across the home. There were no offensive odours and the home was visibly clean. This included bathroom and toilet facilities. We noted in two shared bathrooms that the checklist staff used for recording cleaning the bath, bath hoist, basin, floor and toilet did contain gaps. However, our observation showed the equipment was clean. Staff completed a separate record to show that they regularly checked people's mattresses and ensured they were clean.

Certificates showed equipment within the home, such as hoists, hot water and central heating boilers, fire detections system and electrical appliances were maintained safely.

Good

Is the service effective?

Our findings

At our last comprehensive inspection in January 2018 we rated this key question 'Requires Improvement'. We had concerns that staff knowledge of the Mental Capacity Act 2005 (MCA) required improvement. We were also concerned that whilst staff had access to training they did not always have the necessary skills to support people living with specific conditions such as dementia. People also had mixed views on the quality of the food provided at the home. At this inspection we found improvements had been made and the registered manager had ensured appropriate action had been taken.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff confirmed that they had now received training in the MCA and DoLS so that they understood how to support people who were not always able to make decisions for themselves. They gave us examples of how they respected people's decisions but also tried to secure people's cooperation. They also understood when essential support, such as with personal care was needed and described a process of persuasion, approaching people at different times or involving different colleagues to secure consent where possible. A relative told us, "I know that [family member] having personal care can be difficult. They [staff] don't take it personally. They know [family member's] ways and quirks and can manage it."

A log of DoLS applications and renewal dates was held and monitored in the service. This demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes.

Staff had received the training and support that they needed to work effectively in the home. People and their relatives told us staff were well trained. One person said, "I know they have regular training, one of the [staff] told me tomorrow they will be going upstairs for some training."

Staff training was planned to ensure that they had the skills required to meet people's individual needs and staff were following best practice guidance. For example, staff had completed training about understanding dementia and supporting people effectively. Staff told us that they kept their training up to date. They said that a lot of training was eLearning using the computer. They also had practical training to ensure they were competent for example in using mobility equipment and in first aid. A long-standing staff member explained that staff who were new to the home worked with more experienced colleagues to gain competence and understanding of people's needs prior to working alone.

The registered manager told us that when they first started managing the home compliance with training by all staff had been at 45% completion. They described how they had worked hard to increase that to 95% compliance. A relative told us how their family member's needs had changed considerably following surgery. They expressed their satisfaction that staff received prompt training in using new equipment so that they could support their family member properly. This meant people were being supported by staff who had received the necessary training to carry out their job roles.

New staff who did not already hold a recognised health and social care qualification were supported to undertake The Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers new to care work should adhere to in order to deliver caring, compassionate and quality care.

The registered manager had identified that improvements to staff supervision and appraisal were required when they were appointed. We saw that they had identified the aim to improve this as one of three keys actions. Staff confirmed that they now received formal supervision. Supervision is needed so that staff have opportunities to discuss their performance and development needs on a regular basis. However, staff were not always clear and confident about how often formal supervision should take place. For example, one staff member told us who they 'thought' was their supervisor. When we asked how often they should have formal supervision they told us that they thought it should happen about once every six months. However, staff went on to tell us that they felt well supported by senior colleagues and could go to the management team at any time with anything they were not sure about. One member of staff said, "I do feel supported better now, the team is more settled."

People's needs were assessed to ensure that staff could meet them effectively. We saw that this included assessing what people found important about their care and what could contribute to them experiencing a meaningful lifestyle. Nursing staff and care staff contributed to these assessments with people. The lead lifestyle coordinator explained how they tried to complete the care plan assessments for social history and lifestyle themselves with people with the aim of contributing towards a holistic approach in delivering care.

We received positive feedback from people about their meals and choice of food. One person commented, "The choices are good. You get two choices of a hot meal at supper time and you can have something lighter for lunch and what you fancy for your breakfast. There's always plenty to eat and drink." Another person told us, "The food's alright for me. I eat my meals here in the dining room. I've just had cereal for breakfast." A third person said, "Some people here grumble about the food, I don't know what they expect, it's not too bad… at dinner there's a choice and, of course, at lunch you can always have something else like a salad, or some cold meat or sandwiches."

A relative told us that they felt the quality of food people received had improved since the new registered manager took over the service. A recent consultation had been carried out at the home and as a result the main meal of the day had been moved to the evening meal and lunch was now a 'lighter' option. We observed lunchtime and the mealtime experience across the home. We saw that staff were available to assist people with their meals when they needed it. For example, staff asked people if they needed help to cut up their food. There was still a choice of hot dish available at lunch time. However, we saw that one person had asked for and was given sandwiches as an alternative. There was also soup and a substantial dessert of crumble and custard on offer. We noted that there was also a choice of meals at tea time when the main meal of the day was scheduled.

The registered manager had made a number of changes to the mealtime experience since commencing employment at the home and told us, "I was shocked when I saw the mealtime experience here. Staff

weren't using the dining space very well, lots of people crammed into one area. We've made improvements to the seating areas. Also, people are now offered their meals from a 'show and tell' plate so they can see the actual food to choose from."

We noted that fluid monitoring charts were in place for people who were considered at risk of not eating or drinking enough. A staff member also told us how they routinely monitored people who were new to the service. This was for a period of three days so that they could establish whether there was any additional support or intervention they needed to make to ensure a healthy diet and intake of drinks. Care staff asked people if they wanted a hot drink on a regular basis as they passed through the home. Some people chose to spend time in the coffee bar area and staff offered to assist them with drinks when they were there. One person said, "I like that I can come down to the café and have a drink and a chat with other [people], I can have as much coffee as I want." Relatives could also, for a small donation, help themselves to hot drinks and cakes in the café area.

There were regular checks to ensure that people maintained a healthy weight. We noted that, for one person who had experienced weight loss, their care records showed staff increased the monitoring and encouragement they offered. The person had regained some of this weight, and despite the period of weight loss, they had maintained a Body Mass Index (BMI) within the average range. For two other people we checked, their BMI was also within the average range despite minor fluctuations. The management team maintained an oversight of changes and we noted that care records showed when staff sought advice from a dietitian.

A relative told us that they felt staff had been very alert to changes in their family member's wellbeing and sought hospital treatment promptly in response to a serious change. They told us, "They [staff] saved [family member's] life … I can't thank these guys enough." They went on to explain that staff kept them informed about any changes in their family member's health and wellbeing. Another person's relative told us how staff from the care home had liaised with the hospital after their family member had been admitted. They told us that this had enabled the care home's staff to find out about how the person's treatment affected them and to learn about changes in moving and handling practices they needed to implement.

People's care records showed that, in addition to the home's nursing staff, they received advice from health professionals to help promote their health and wellbeing. This included for example, the dietitian, doctor, district nursing staff, a dentist and diabetic services. Records showed people were involved in discussions with these professionals and the home's staff about their health and welfare. They also took account of whether people understood their health conditions and how they wanted staff to support them.

We looked at how people's needs were reflected in the adaptation, design and decoration of the premises. Accommodation was provided over three floors with level access throughout each so that people who were able to do so, could move around independently. There was a lift between floors to assist people safely rather than using stairs.

Each floor had an array of communal areas that people could access such as a main lounge, a quiet lounge, library, cinema room, hobbies room and potting shed room. One of the lounges was temporarily curtailed due to laundry refurbishment and was being used for ironing and processing clean laundry.

Within the front entrance hall area there was an in-house café which was a central, vibrant and lively hub which we saw people and their relatives utilise throughout the day. This meant there was space available if people wanted to spend quiet time or to talk privately with any relatives or visitors. We saw that there was also dedicated space for activities such as crafts and one person was supported to use this throughout our

inspection visits.

Toilets and bathrooms were clearly marked to encourage independent use and help people who might have difficulties orientating around the premises. We saw there was also signage around the building to assist people to locate different areas of the home. Many people at the home were living with dementia and the home had a dedicated floor of the home where people living with dementia were cared for. As such the provider had sought to make the environment on the designated suite dementia friendly with reminiscence items available on the walls and within the lounge areas.

Good

Is the service caring?

Our findings

At our last comprehensive inspection in January 2018 we rated this key question 'Requires Improvement'. We had concerns that whilst staff treated people with kindness, respect and compassion their ability to do this was sometimes restricted by the time they had available. This was because of the insufficient staffing levels at the home at that time. At this inspection we noted improvements had been made and that staff responded promptly to people's requests for assistance and that they intervened when one person living with dementia became anxious and distressed.

People told us that they were happy with the care they received at Cavell Court. One person told us, "This is a marvellous place. The staff are definitely so caring." Another person said, "I'm happy with everything. I'm very well looked after." A third person commented, "They [care staff] are cheerful and always caring, hand on heart no-one has ever been less than kind and caring [to me]."

Relatives also told us about the caring nature of the staff and the care their family member received. One person's relative said, "The staff are friendly and kind, [family member] is happy here."

Staff took time to communicate with people and to understand what it was they needed or were trying to express. In those care plans we reviewed, there was information about people's communication and whether staff needed to be aware of any difficulties they may have. This included how to approach people who had hearing loss but refused to wear a hearing aid, including making sure their faces were clearly visible to people. In one case we saw that the care records contained detail about the person's differential hearing. Their care plan explained how staff should always approach them from the side they found easiest to hear.

Staff spoken with could explain people's backgrounds and what was important to them. The information they gave us was consistent with what we had seen in people's care plans. We noted that, for one person, staff had been gradually building up a picture of their background and were sensitive to the person's wishes not to discuss aspects of their past they found distressing. One staff member told us, "We've got to be patient with people and respect their views."

A relative told us that they felt staff had a good understanding of people's needs and knew them well. They also said that this was an improvement since our last inspection. Staff expressed confidence that members of the management team also understood people's individual needs so could promote these and advise the care team if they needed to.

Information displayed for people about activities was not always at a height that might be clearly visible and accessible to people who used wheelchairs. However, we also observed that staff explained to people what was happening.

A staff member told us how they were the "dignity champion" for the home and encouraged and supported staff to work in ways that promoted people's dignity. We saw an example of this when a person had started to cough during their meal and was embarrassed about sitting with others. Staff acted promptly and

discreetly to offer reassurance and assistance to move somewhere else where they were more comfortable.

The same staff member explained how they felt there was a different approach to care in the home under the new registered manager. They told us that they felt staff were now "… given licence to spend time with people…" rather than just focussing on daily tasks. One person confirmed this when they told us, "The other day I asked one of the carers if it would be possible to buy me a box of tissues. [Care staff] said, "Hang on a minute" and she went away and came back with my coat and said "Is this your jacket?" I said "Yes, why?" And she said, "Come on then, we'll go across to the shop and you can buy them for yourself. And we did!"

Another staff member explained to us how they offered people choices daily, for example about what they wanted to wear and whether they preferred a bath or shower.

Throughout our inspection visits, we observed that staff spoke with people in a friendly, jovial but also respectful way. Staff also knocked on people's doors before entering their rooms to offer support and closed bedroom doors when they delivered care. We saw staff position themselves to be at eye level with people when speaking with them. Staff called people by their preferred name, and adapted their communication techniques and approaches to accommodate people with communication and sensory difficulties.

Good

Is the service responsive?

Our findings

At our last comprehensive inspection in January 2018 we rated this key question 'Requires Improvement' and found a breach of Regulations 9 and 16 of the HSCA RA Regulations 2014. We were concerned that the service was not consistently responsive. Information within people's care plans at that time was not always comprehensive and up to date. We found there were also varied views about how the service supported people with social activities and social engagement. We were not confident that people always received the care and support they needed. At this inspection we found that improvements had been made.

Staff maintained people's care plans and most associated records in an electronic format. These flagged up when aspects of care needed review to ensure plans for responding to people's needs were up to date. We saw from the computer records that staff made note of the discussions they had with people to show their involvement in planning care and their wishes.

The lead lifestyle coordinator explained to us how people were involved in the way the home was run. They told us that the in-house shop was stocked with items that were based on people's views and suggestions. They said, "It was their idea for the shop and what they wanted to see in it." They went on to explain how they had ideas about developing roles for 'residents' representatives', describing their vision as this being like "… a union rep." They envisaged that this would encompass advocacy for the resident group with potential participation in staff interviews and holding or chairing residents' meetings.

A relative told us that they felt activities within the home had improved a great deal following the change of management. They said, "Activities have improved. It's amazing now. The team are always thinking up different things to do." They described how much people had enjoyed a recent event to celebrate bonfire night.

Staff understood people's individual needs including whether they preferred to spend time alone or in small group activities, rather than large groups. They could tell us about this and what people's preferences were. We noted that one person had expressed a wish to attend religious services although their activities care plan lacked detail about some of the things they did and about whether they were able to practice their religion as they wished. However, on further discussion we noted that the provision of church services within the home was a recent development.

The lead lifestyle coordinator also explained how the person had been able to join in religious celebrations of Edith Cavell's life, that took place in Norwich Cathedral. Staff told us how they were invited to submit a life-sized angel model for an exhibition. One person was very actively engaged in planning how this would look and constructing the wings for it with staff support. We observed that "prayer boxes" were in place for people or their relatives to drop notes in for the local clergy so they could receive some spiritual comfort.

Care records reflected people's hobbies and interests. On the ground floor we noted during the day that there was always something happening for people to engage in. This included a yoga activity. Staff described one person who liked their own company or to join small activities, recognising the yoga session

as beneficial for their health and therefore joining in when they wished.

Improvements had been made to the way complaints were handled. Arrangements were now in place to ensure people's concerns and complaints were investigated, responded to and used to improve the quality of the service. The registered manager told us that when they first started working at the home they immediately picked up and responded to 12 existing and outstanding complaints and that since then they had ensured the response to any concerns raised was in line with the provider policy. A relative explained to us that they felt the new manager's approach to managing complaints was constructive. They told us that they felt, at the time of our last inspection, their concerns were not listened to. They expressed their confidence that this was no longer the case.

Where people were in receipt of end of life care, the provider ensured that people were still enabled to live their lives in line with their preferences. Where appropriate, people had end-of-life anticipatory medicines in place, in case they needed them and these were also clearly reflected within people's medicines records. Some people had 'do not attempt cardio pulmonary resuscitation' (DNACPR) orders on file as well as Advance Care Plans; these had all been completed with the involvement of appropriate healthcare professionals and relatives.

At the time of our visit the staff team was supporting some people to receive care at the end of their lives. There was variable practice in the amount of detail that people's care records contained about their last wishes, preferences and advance decisions however some people had not been prepared to discuss their end of life wishes in the event of deteriorating health. One relative contacted us about their family member's end of life care at Cavell Court and told us, "I can only speak highly of them [care staff]. Family member has built up bonds with all staff and knows them and can chat with staff. All know [family member] and pop up and say hello now they can no longer get out of bed. [Family member] told them they wanted to go [specific activity] and they made it happen. It was a big deal and involved lots of organising. They made it happen, [family member] only went once because of declining health but it was fantastic."

The registered manager said that they had plans to improve and increase training for staff in end of life care so that staff understood best practice and that now they had made 'headway' with lot of the improvements needed overall at the home they could begin to focus on further developments such as working towards accreditation in the Gold Standards Framework, and the 'Five Priorities of Care' model of support for people at the end of their lives.

Good

Is the service well-led?

Our findings

At our last comprehensive inspection in January 2018 we rated this key question 'Inadequate' and found a breach of Regulation 17 of the HSCA RA Regulations 2014. The governance of the service was not effective or robust and this was evidenced by the lack of oversight. That inspection was the third comprehensive inspection since 2016 where we have rated the home requires improvement overall. We had also found a number of breaches of the Regulations overall at the last inspection.

At this inspection we found improvements had been made and were ongoing. We were encouraged by the progress and commitment to improving standards made in the ten months since our last inspection by the management team and the provider. We discussed the need to ensure the improvements continue to be sustained, maintained and fully embedded to ensure people are consistently provided with a safe quality service.

Since we last inspected, an experienced registered manager was recruited to the home from one of the providers other services. The provider had placed multiple additional management resources into the home on a weekly and monthly basis and the registered manager was being closely supported by a quality development manager, the regional director and an operations support manager all of whom were supporting with the necessary improvements and changes. The regional director had 'taken' Cavell Court on to their portfolio of services following our last inspection and told us, "I used to come to the home two to three times a week to start with. Now it's much improved I'm here about weekly but in daily contact. There was a lot to do at first, the home was unloved. They were using an awful lot of nurse agency and now we've got it down to just a 22 hour a week post. My main aim was to get agency usage down and get more stability. Some staff attitudes weren't what we wanted either so some left. It's 99 percent different now, so much has been done."

There was noticeable leadership in the service. The registered manager was very visible, very 'hands on' and clearly knew people very well as she demonstrated an extensive up to date knowledge of all the people living in the home without referring to records. This was apparent as we observed how the registered manager engaged with people with ease and received positive reactions from people, relative and staff.

A relative spoken with was very positive about the changes the registered manager had made within the service since her appointment. They said, "[Registered manager] has put in a lot of hard work … staff give the impression it is more positive all round." They also complimented the staff team and said, "They need recognition for what they have been doing." They went on to tell us, "They [staff] are not just smiley today because of you [CQC] being here … that is how they always are."

Staff members were also positive about the changes the registered manager had brought about. One told us, "I've seen a lot of changes. [Registered manager] has turned it around. There's back up from head office and lots of changes for the better." They described staff morale as, "…99.9 percent better." They spoke passionately and enthusiastically about their work. They felt that care standards were good and that now they would, "…most definitely…" be happy for one of their family members to be cared for at Cavell Court.

Another staff member described the registered manager's approach as, "…firm but fair." They told us staff morale was much better and that the registered manager had an open-door policy. The registered manager told us, "Staff were really upset about the last [CQC inspection] report especially caring. They've had six or seven managers here and no stability."

Audits systems included regular checks made by the provider, manager and senior staff. These were daily and weekly checks of the service and a monthly visit from the provider. Audits covered all areas of the service such as, health and safety, infection control, medicines management, complaints and nutrition. The provider visits were detailed, including observations of staff and discussions with people and their relatives.

The registered manager was looking to increase the involvement of people and seek their opinions. They had already carried out a consultation on moving the main meal of the day from lunch time to tea time, following which they were looking to review whether people wished to continue with. The service was also looking to introduce a 'resident' representatives committee where people could become more involved in the service as well as 'dot voting' where people could vote on developments within the service. All of this helped people to become engaged and involved in the running of their home.

We found minutes of regular meetings held with people and relatives. These were used to measure quality and gain feedback on the services offered, such as activities. These were recorded and made available for those who could not attend. The provider worked with the wider community in supporting people's health and wellbeing. We saw interaction between the home and local schools, churches and community groups.

The service worked in partnership with other organisations to make sure they followed current practice. For example, healthcare professionals such as G.P's, district nurses and speech and language therapists. This ensured a multi-disciplinary approach had been taken to support the care of people living at the service.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the Care Quality Commission (CQC). We checked the records at the service and we found that all incidents had been recorded, investigated and reported correctly.