The Old School House Limited

The Old School House and Courtyard Nursing Home

Inspection report

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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

Summary of findings

Overall summary

This inspection took place on 16 and 21 November 2017. The first inspection day was unannounced and we told the manager we would be returning to the home on 21 November 2017 to conclude the inspection.

At a focused inspection of the service in June 2017 we identified a breach of regulation in respect of the management of medicines. Storage and recording of controlled drugs was not satisfactory and some of the recommendations made in medicines audits undertaken by health care professionals had not been actioned. At this inspection we found that improvements had been made and the provider was no longer in breach of this regulation.

At our previous comprehensive inspection in October 2015 we judged the service to be Requires Improvement in Safe and Good in all other areas. There was no breach of regulation at this time but we made a recommendation about the need for service and maintenance certificates to be up to date. At this inspection we found improvements had been made.

The Old School House and Courtyard Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide accommodation and care for up to 42 older people, some of whom may be living with dementia. There were 36 people living at the home on the day of the inspection. The home is divided into three areas: The Old School House, The Courtyard and The Bungalow and each is staffed separately. All of the accommodation is on one level.

The manager had submitted their application for registration to CQC and it is currently being processed. They were previously the registered manager of another service belonging to the same provider. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that staff lacked knowledge of the Mental Capacity Act 2005 (MCA). The manager had identified this as a training need and was in the process of sourcing detailed training in this subject. In the interim, training workbooks and a specific module of training on the MCA had commenced to address the immediate need.

Induction training was not in-depth and there were shortfalls in other staff training such as moving and handling, infection control, fire safety and dementia awareness. This had been recognised by the manager and plans put in place to bring training up to date. However, in the interim period there was a risk that people were being supported by staff who lacked the knowledge they needed to carry out their roles effectively.

People had care plans in place but these did not always contain up to date information, and associated monitoring charts had been completed inconsistently. This meant that staff did not always have current information available to them so they could support people appropriately. This had been identified and care plans were in the process of being improved.

Quality monitoring of the service had been strengthened and areas that required improvement had been identified. The manager completed regular audits to check the quality and safety of the service.

Staff had not been recruited following the organisation's policies and procedures and we made a recommendation about this in the report.

There were sufficient numbers of staff employed to meet the needs of people who currently lived at the home.

People told us they were happy with the choice of meals provided at the home. Nutritional needs had been assessed, people's special diets were catered for and food and fluid intake was being monitored when this was an area of concern. However, these records were seen to be inconsistent.

Staff received training on safeguarding adults from abuse. They were able to describe different types of abuse they may become aware of and the action they would take to protect people from harm. People told us they felt safe living at the home.

Accidents and incidents were recorded appropriately and had been analysed to identify any patterns or trends, and any areas that required improvement.

Staff were kind, caring and patient. They encouraged people to be as independent as possible and respected their privacy and dignity. It was clear that staff knew people well and this helped them to provide person-centred care.

People understood how to express any concerns or complaints and any complaints made had been investigated appropriately. People were able to give feedback on the service they received, although meetings for people who lived at the home or relatives were minimal.

Supervision meetings and staff meetings had been infrequent. However, these had been reinstated and staff told us they were well supported by the new manager.

You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Staff recruitment was not robust although sufficient numbers of staff were employed to support people who currently lived at the home.

Staff had received training on safeguarding adults from abuse and were confident if they raised any concerns they would be dealt with effectively.

Medicines management was robust.

The home was clean although some minor repairs were required to promote effective prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had only a basic understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), although people were supported with decision making. Staff induction training needed to be in more detail.

People told us they enjoyed the meals at the home and we found their individual nutritional needs were assessed and met.

People had access to health care professionals when needed.

The premises were suitable for the people who lived at the home; there was some signage to assist people with locating their room and other areas of the home.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and there were positive relationships between people who lived at the home and staff.

People's privacy and dignity was respected by staff and their

independence was promoted.

Information about advocacy services was available within the home should people need this support to express their views.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had care plans in place that described their individual support needs but some information, including monitoring charts, had not been completed consistently.

Activities were provided and there were plans in place to ensure people had more social stimulation.

There was a complaints policy and procedure in place and complaints had been investigated appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The manager in post had applied to be registered with the CQC in October 2017; this application was currently being addressed.

People told us that numerous improvements had been made since the new manager had been appointed and that the manager was approachable.

Quality monitoring of the service had been strengthened and areas that required improvement had been identified.

We noted minor omissions in some care plans and associated monitoring forms. This was being addressed with the on-going transfer to a new care plan format.

The Old School House and Courtyard Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 was a comprehensive inspection that took place on 16 and 21 November 2017. The first day was unannounced and we told the provider that we would be returning to conclude the inspection on 21 November 2017. Day one of the inspection was carried out by two adult social care inspectors and an expert-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. Day two of the inspection was carried out by one adult social care inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the provider. Notifications are documents that the provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

Prior to the inspection we had received numerous safeguarding concerns from various sources. In addition to this, the local authority had issued the provider with a formal improvement notice on 28 September 2017. These concerns were considered as part of this inspection.

During the inspection we spoke with three people who lived at the home, five members of staff, four family members/visitors, a health care professional, the manager and the quality manager. 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 cannot talk with us.

We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for six people who lived at the home, the recruitment and induction records for two members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Requires Improvement

Is the service safe?

Our findings

At the focused inspection in June 2017 we had concerns about the management of medicines. Concerns had also been expressed by other health and social care professionals, and as a result, medicines audits had been carried out by health care professionals. We saw that, although some of their recommendations had been carried out, others had not. In addition to this, controlled drugs were not being stored and recorded accurately. Controlled drugs are medicines that have specific storage and recording requirements. At this inspection we saw that the provider had made improvements to ensure that medicines (including controlled drugs) were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. Medication administration records (MARs) were an accurate record of the medicines administered. The temperature of the medicine room and medicine fridge were taken to ensure medicines were stored at the correct temperature. Only senior staff had responsibility for the administration of medicines and we saw evidence that they had received appropriate training.

This meant the provider was no longer in breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the comprehensive inspection in October 2015 we made a recommendation about the need for service and maintenance certificates to be up to date, to evidence the equipment and premises were safe. At this inspection we reviewed service certificates. These evidenced that equipment and systems such as portable appliances, the water supply, gas appliances and systems, hoists and pressure care mattresses had been serviced. However, the electrical installation certificate showed that there had been some unsatisfactory areas at the last maintenance check. The manager had recognised this and had arranged for an engineer to visit the home to recheck the system and carry out any necessary repairs. The engineer was due to commence this work during week commencing 20 November 2017.

There was a fire risk assessment in place, and the fire alarm system and emergency lighting had been checked in August 2017. Fire drills had taken place and records showed that staff responded quickly. The home's handyperson carried out checks on call bells, fire extinguishers, bed/grab rails, window opening restrictors and water temperatures, as well as carrying out day to day repairs.

People told us they felt safe living at the home. One person said, "Knowing someone is here, three or four minutes and staff come [if call bell pressed]." Staff explained to us how they kept people safe such as following their moving and handling and hoist training and making sure there were no obstacles that created a risk of falls. We saw that staff assisted people to mobilise using safe techniques and appropriate equipment. When risks had been identified in respect of people's care, action was taken to minimise potential risks without undue restrictions being placed on them. We saw risk assessments in respect of diabetes, falls, nutrition, use of hoists and pressure area care. Appropriate equipment had been obtained to reduce the risk of people developing pressure sores.

Staff had received training on safeguarding adults from abuse. They were able to describe different types of

abuse they may become aware of and told us they would report any concerns to the registered manager. However, a safeguarding concern in respect of catheter care for a person who previously lived at the home had been investigated by the local authority and the outcome was that neglect had occurred. The manager was confident that monitoring was now more robust and a similar situation would not occur again. Staff also told us they would use the home's whistle blowing policy and were confident the information would remain confidential. A whistle-blower is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

A health care professional told us they had been working with care staff to produce care plans that included information on how to manage behaviours that might challenge the service. We saw that some care plans included this information, plus any identified triggers and signs that the person was becoming distressed.

Staff were required to sign a document to evidence they had read the home's policies and procedures. We reviewed the new nutrition and hydration policy, and the policies for medicines management, safeguarding adults from abuse and the prevention and control of infection. We found these to contain appropriate information including good practice guidance.

The manager told us there were two senior care workers and six care workers on duty each day. Two care workers were based in The Old School House, three were based in The Courtyard and one was based in The Bungalow. The manager and the deputy manager were on duty each day, Monday to Friday. There were four or five staff on duty overnight across the home, including a senior care worker. We noted that staff were visible in communal areas of the home and that people received attention promptly. In addition to care workers, there were two domestic staff, a cook and a kitchen assistant on duty; this meant care workers were able to concentrate on supporting people who lived at the home.

We received differing feedback about staffing levels from people who lived at the home and relatives. One person told us, "A few people require a lot of assistance, and it means someone has to wait" but another person said, "There's always a carer around, I help the staff out, I wash up and do some cooking." (This was a person who lived quite independently). Comments from relatives included, "Seems to be [enough staff]. You press the call bell and odd times have a 15 minute wait", "Yes, I visit every day and there's always a carer in the lounge" and "Plenty of staff." A health care professional told us they could always find a member of staff when they needed them; although they felt staffing levels were 'tight'. However, they added that they had found this in every care home they visited. Staff told us they coped well when there were six care workers on duty, but struggled when this reduced to five. Over lunch there was a period of 15 minutes when there were no staff in the dining room to supervise people. We fed this back to the manager who told us that staff were aware there should be a staff presence in communal areas at all times. We noted that for the rest of the day and during our second inspection day there was always a staff presence in lounge and dining areas. Overall, we concluded there were sufficient numbers of staff on duty.

We checked the recruitment records for two members of staff. One person had a Disclosure and Barring Service (DBS) check in place prior to them commencing work, but the other person's DBS check was not dated. This meant it was not possible to confirm that this check was in place prior to them starting work at the home. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. One person did not have any employment references in place. The manager had carried out an audit of recruitment records and this omission had been identified. The service had already started to obtain references in retrospect. However, in the interim period there was a lack of evidence that people who were working at the home were considered suitable to work with vulnerable people.

We recommend that the home's policy and procedure on safe recruitment practices is followed consistently.

Accidents and incidents were recorded, analysed monthly and audited to identify any patterns that might be emerging or improvements that needed to be made. We reviewed the analysis of accidents carried out in August, September and October 2017. This included details of any medical attention that was sought and any new equipment that was provided to reduce the risk of the same incident reoccurring. Staff told us that they learned from incidents at the home. One staff member told us they discussed any falls or accidents and, for example, may move furniture around to prevent the same incident occurring again.

There was a business continuity plan that provided advice for staff on how to deal with unexpected emergencies, such as a pandemic, loss of utilities or a gas leak. Each person had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to evacuate the premises.

Everyone who we spoke with told us that the home was maintained in a clean and hygienic condition and we observed this on the day of the inspection. We advised that more care needed to be taken with the storage of disposable gloves so they were easily accessible for staff but not accessible to people who used the service; disposable gloves pose a risk if they are accidentally ingested. Some minor areas required improvement, such as a rusty toilet frame and the flooring in one bathroom not being intact therefore difficult to clean. The manager assured us these issues would be dealt with immediately. Laundry facilities were satisfactory. We noted that the home had received a food hygiene score of five, which is the highest score available. The inspection had been carried out by the health and safety team of the local authority, and checked hygiene standards and food safety in the home's kitchen.

Requires Improvement

Is the service effective?

Our findings

Staff confirmed that they had induction training when they were new in post although the records we saw showed this training primarily consisted of orientation to the home. The manager acknowledged that induction training needed to be strengthened to provide evidence that staff were competent when they first started to work at the home. The manager also told us that new staff would work towards the Care Certificate in future. This would ensure that new staff had received a standardised induction in line with national standards.

The training record showed that most staff had completed training considered to be essential by the provider. This consisted of safeguarding adults from abuse, dementia awareness, and infection control and fire safety. However, some staff had not completed this training. The manager had compiled a list of the training each member of staff needed to complete so they were up to date with their training requirements. A small number of staff had completed training on equality and diversity, challenging behaviour and person-centred care. Twelve of the 33 care staff employed had achieved a National Vocational Qualification (or equivalent) at Level two or three and one member of staff was working towards this award at Level five.

A health care professional told us that staff lacked knowledge around people living with dementia, although they were open to advice. The health care professional had offered additional training to care staff and the manager had accepted this offer. This showed the manager was keen to bring staff training up to date and make sure staff were aware of good practice guidance in respect of supporting people who were living with dementia.

Although the manager had put a plan in place to bring people's training up to date, there were gaps in the training considered to be essential by the home.

This was a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The above information contributed to the breach of Regulation 18 (1) (2) (a) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Records showed that supervision meetings had previously been infrequent. Supervision meetings give staff the opportunity to discuss any concerns they might have, as well as their development needs. The manager had identified this; they had produced a supervision plan and had started to hold supervision meetings with staff. Staff told us they felt more supported since the new manager had been in post. One staff member said, "I have got loads off my chest."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty

Safeguards (DoLS). We saw DoLS applications had been submitted to the local authority appropriately.

Although 50% of care staff had completed training on MCA and/or DoLS, we found that staff lacked knowledge of the MCA. This had been identified by the manager and there was an on-going plan which had commenced for staff to complete training which included workbooks and specific modules in this subject. The manager also told us they were in the process of sourcing detailed face to face training for staff. We asked people who lived at the home if they were consulted about their care and if staff asked for consent. They told us, "Staff ask, I feel they tell me (what they are doing)" and "I think so, they are polite." There were consent forms in place in respect of photography and staff administering medicines. Some people had signed these forms but other people had not signed them as they lacked the capacity to understand this information. The manager was aware that people's relatives could only sign these forms if they had been appointed as lasting power of attorney (LPOA) for health and welfare. A LPOA lets people appoint one or more people to help them make decisions on their behalf.

When someone had a LPOA to act on their behalf, this was recorded in their care plan. There was evidence that some people had been assisted to make decisions in their best interests with the input of health professionals and relatives, such as remaining at the home on a permanent basis and their fluid intake being monitored by staff. Staff described to us how they encouraged people to make day to day decisions, such as showing them meals and clothes, but reminded them about appropriate dress depending on the weather. One member of staff said, "We might describe to people what they had to eat the previous day to help them made a decision about today."

It was clear to us that communication between people who lived at the home and staff was effective, whatever the person's form of communication. People told us, "Carers chat anytime they come in, they told us about your CQC visit due, and they tell us if there are any emergencies" and "Carers chat to me, I understand them." A member of staff said, "Most people can say a few words. We use pictures to help some people and write on a board for other people."

Relatives also told us that communication with them was good. One relative said, "Yes, they always tell me when I visit (daily)." We saw that a board displayed the names and photographs of the staff on duty each day. The home produced a newsletter that helped keep people who lived at the home and relatives up to date with information and events. The current newsletter informed people that the previous manager had left the home and welcomed the new manager. Activities planned for the rest of November and December 2017 were included, and people were reminded that any feedback, suggestions or ideas were welcomed.

People were supported by GPs, community nurses and other health care professionals. One person told us staff had accompanied them to hospital appointments and another person told us the district nurse visited them every week. All contacts were recorded; this included any advice given by health care professionals. Details of a person's health conditions were included in their care plan. One person's records indicated that staff had noticed they were unwell but had not taken any action until their relative arrived at the home. At this stage medical attention was sought and an ambulance arrived to take them to hospital. This showed that there had previously been a lack of prompt attention paid to people's changing needs. We concluded that this was a 'one off' occurrence as there was no other information to suggest this had happened to other people who lived at the home.

We received positive feedback about meals provided at the home. Comments included, "Brilliant, usually a choice, roast on Sundays", "If you feel like egg and chips, you ask and get it." We observed the lunchtime experience and it was apparent that staff encouraged this as an opportunity for people to socialise. People were offered a choice of food and drink; they were supported appropriately by staff and allowed to eat at

their own pace. One person was assisted by their relative to eat their meal. We fed back to the manager that dining tables were not set with cloths or napkins and seemed 'bare'. They acknowledged this as something they had noted and intended to improve.

People's special dietary requirements and their likes and dislikes were recorded in their care plan. In The Courtyard we saw a list of people who required special diets and what these were. Staff told us that this list was no longer up to date, although they were able to explain people's current requirements to us. This list was corrected on the day of the inspection. People had appropriate nutritional assessments and risk assessments in place. Advice had been sought from dieticians or speech and language therapy services when concerns had been identified about people's nutritional intake or their risk of choking. Any advice given had been recorded in the person's care plan. The cook showed us the list in the kitchen of people's special dietary requirements. One person was vegetarian and had requested that the cook prepare them a vegetarian curry, which the cook planned to do.

Most people required some assistance with locating areas of the home and directional signage was in place to help with this. One person told us, "Yes, I'm happy, they tell me I can go where I want to." A relative said, "Yes, there's enough signage, there is a photo of [name of relative] on their bedroom door." We also saw these on the day of the inspection. Staff told us that people sat in the garden when the weather was suitable and that there was an enclosed courtyard area where people could be safe.

Some wheelchairs and walking frames were stored in an area of the home which had become quite cluttered. The manager acknowledged they were short of storage space. They intended to clear out a shed in the garden so that equipment could be stored in it.

Good

Is the service caring?

Our findings

We observed that people had positive relationships with staff and that staff were attentive to people's individual needs. One person told us, "They sit and listen to me which shows they care about me." Relatives told us, "They do a lovely job" and "[Staff] seem so helpful and nice." One relative told us their family member had been poorly the previous week and had not eaten breakfast or lunch. The cook came to see them and asked them what they fancied to eat. They offered to make them some soup or scrambled eggs. The relative felt this demonstrated a caring attitude by all staff.

A health care professional said, "Staff genuinely care. We have been holding small clinics and care workers accompany people who live at the home at these appointments. It is good to hear the care workers' points of view." They added, "Staff have a kind attitude and a sense of humour." A member of staff told us about one person who had no family visiting them. They said they knew which sweets this person liked, so staff bought these for them. A member of staff also told us they enjoyed working on Christmas Day. They said there was a lovely atmosphere and the service bought people who lived at the home one or two presents.

During our observations, we noted staff respected people's individual choices and preferences. We could see that people dressed in their chosen style and females wore makeup and jewellery if this was their choice.

We asked people if they were treated with dignity and respect by staff. One person told us, "Yes, and I can ask for a bath or shower whenever I want". Staff described to us how they protected people's modesty when assisting them with personal care, such as closing doors and curtains and keeping people covered to protect their modesty. A member of staff told us that two females had requested they were only supported with personal care by female care workers, and this was always respected.

Staff told us they encouraged people to maintain their independence, especially in respect of their personal care. One member of staff told us, "We encourage people to do what they can for themselves." A relative told us, "Yes, my relative can eat without assistance - they don't like help" and "They are encouraging [name of relative] to walk."

People were supported to keep in touch with family and friends. Relatives confirmed they were able to visit at any time and were always made welcome by staff. A staff member said, "I think families find staff easy to approach."

There was information about advocacy services in the home. Advocacy services help vulnerable people access information and services, be involved in decisions about their lives and explore choices.

We saw that written and electronic information about people who lived at the home and staff was stored securely. This protected people's confidentiality.

Requires Improvement

Is the service responsive?

Our findings

A care plan had been developed from the person's initial assessment, and information gained from relatives and health and social care professionals when needed. Assessments included the use of recognised assessment tools for pressure area care and nutrition. Care plan topics included bathing/showering, pressure area care, continence, communication, nutrition/fluids, personal care, religious needs and end of life care. They also included information about people's daily routines and their preferences for care.

The provider had introduced a new care plan format. Care plans in the 'old' style contained limited information, and we saw that the 'new' style of care plan contained more detail and was more person-centred. Staff told us care plans included sufficient information to enable them to be able to provide person-centred care. For example, the Life Story document contained information about people's family relationships, previous employment and hobbies and interests. One member of staff said, "We treat people as individuals."

The manager told us that they had undertaken a care plan audit when they were new in post. This identified that care plans needed to be reviewed and updated. Some care plans had been updated but others still needed to be completed. These contained a note stating, 'Please be aware that this file is being updated'.

Care plans were reviewed each month. However, we found some anomalies in care plans, including some monitoring charts which were not being completed or not being completed consistently. A relative told us that their family member was supposed to have care workers come to their room every hour and support them to stand up to relieve pressure. They said this was done initially but was now inconsistent. Another person's care plan recorded they had a pressure cushion in place and they needed to be assisted to stand up each hour to relieve pressure. There was no monitoring chart in place to record this.

We reviewed a selection of staff handover records. These showed that each person was discussed and this included information about the previous few days as well as the actual day. Liaison with health and social care professionals was included in these records. This helped staff to monitor people's health concerns on an on-going basis and monitor any changes.

A health care professional told us they had been working with staff at the home to develop advanced care plans. Some care plans included information about people's wishes for care at the end of their life, and recorded that this had been discussed with the person's family.

People told us that their family and friends were made welcome at the home. One member of staff told us, "We read people's letters and postcards to them, and people can speak to friends and relatives over the phone."

There had been no activities coordinator at the home. The manager had recognised that this was an area that required more input and the week before the inspection an existing member of staff had been offered the position of activities coordinator. They told us they would be checking people's care plans so they were

aware of their hobbies and interests, and that they planned to provide arts and crafts, bingo and dominoes. Contact had been made with a local church about providing a church service within the home and they were planning to contact the local primary school to strengthen relationships between the home and the school. Any activities that people took part in were recorded in an activities log and this showed that, during the summer, some people had been on trips to the coast. A health care professional told us, "I think staff would like to have more time to spend with people on therapeutic and life story work but basic needs come first." The activities coordinator told us they planned to spend one to one time with people as well as organising group activities.

Staff gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to disability, gender, ethnicity, faith and sexual orientation. These needs were recorded in care plans and all staff we spoke to knew the needs of each person well. One person who was having a respite stay at the service told us how their individual needs were met.

During our SOFI inspection we saw that staff interactions with people were sometimes task focused such as offering people food and drink rather than trying to engage them in conversation or activities. This was fed back to the manager who told us they would address this with all staff including the new activities coordinator when they had settled into their post.

The complaints policy was displayed in the home and people and their relatives told us they knew how to complain or express concerns. People told us the names of the managers or staff who they would complaint to, and said they were approachable. One person said, "Believe me, I would tell". Relatives confirmed they knew who to speak with and would feel comfortable raising concerns or complaints. We checked the complaints log and saw that any complaints made during the previous 12 months had been investigated and the complainant had been given feedback.

Requires Improvement

Is the service well-led?

Our findings

The manager in post at the time of this inspection was in the process of applying to be registered with the CQC and an application had been submitted in October 2017. A registered manager is a person who has registered with CQC to manage the service. Like providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We asked for a variety of records and documents during our inspection; we found that these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. We found that notifications had been submitted by the manager when required.

When the manager took over the role there were historic issues on-going at the service which had led to a formal improvement notice being issued by the Local Authority (LA). The manager had identified these issues and was engaging regularly with the LA with improvements being noted.

We saw the manager conducted various audits and then completed an action plan that prioritised the improvements that needed to be made. This was divided into Safe, Effective, Caring, Responsive and Well-led and the manager told us they had initially decided to concentrate on Safe. They had identified that some requirements from the previous inspections were still outstanding and had prioritised these. A health care professional told us that things at the home had improved since the new manager had been employed. They said, "The new manager has made a difference. There is a good team of staff now and they welcome advice."

There were systems in place to monitor the quality of the service provided, including satisfaction surveys, meetings and audits. Surveys had been distributed to staff in August and September 2017 and the quality manager explained the outcome to us. This survey was due to be conducted again at the end of 2018. There was a plan in place for surveys to be distributed to people who lived at the home, visitors and health care professionals in the first quarter of 2018. The notice board recorded a 'You said / We did' document. For example, 'You said: we didn't have enough staff' and 'We did: we have recruited two more full time staff and one will remain in the lounge at all times'. The notice also recorded that a spa bathroom had been installed and lounge areas had been renovated.

We saw the health and safety audits for July, August, September and October 2017. Other audits were carried out on various topics, including care plans, accidents and incidents and catering. Any areas for improvement were identified and on most occasions there was a record of when these had been actioned. Infection control audits had been carried out each month; the audit in July 2017 recorded that staff required further training and this would be arranged. We saw the action plan confirmed that this was on-going and some staff had completed the training in August and September 2017.

We noted minor omissions in some care plans and associated monitoring forms. This was being addressed

with the on-going transfer to a new care plan format.

The manager completed a weekly report that recorded how they were progressing against their action plan, staff supervision, staffing issues and complaints. In addition, an operations manager for the organisation completed a monthly audit of the home. This recorded occupancy levels, accidents and incidents, skin integrity, weight loss, complaints and safeguarding incidents. This showed the systems at the home were being monitored by senior managers as well as the home manager.

Staff told us they attended meetings and we saw the minutes of the most recent staff and senior care worker meetings. Staff told us they could raise issues and ask questions at these meetings. One member of staff said, "People were more relaxed at the last staff meeting. People were actually laughing."

Staff told us they were happy with how the home was managed. Comments included, "The new manager is very laid back but gets things sorted. The home is now well managed" and "Things have improved. I enjoy work more. [Name of manager] is taking us under his wing." The manager was supported by a deputy manager and they were they were both supernumerary when they were at work; this meant they were additional to the staffing levels recorded on the staff rota.

The manager described the culture of the service as, 'A good culture of care. It's becoming a more warm and open culture." A health care professional told us, "Staff as a team seem to gel. They are very open. You can grab anyone and they are willing to help." Relatives told us there was a positive culture at the home and staff told us there was a welcoming atmosphere at the home and they would recommend the home to their family. Comments from staff included, "The home is well managed and carers genuinely care" and "The home feels like a big family. You get attached to people and treat them like you would your own family."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: Staff had not always received appropriate support, training, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a)