Norfolk Care Homes Ltd

Iceni House

Inspection report

Jack Boddy Way
Swaffham
Norfolk
PE37 7HJ

Tel: 01760720330
Website: www.zestcarehomes.co.uk

Date of inspection visit:
03 October 2017

Date of publication:
19 December 2017

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

The inspection took place on 4 October 2017 and was unannounced. At the last inspection on the 7 September 2016, the service was rated as requires improvement in every key line of enquiry we inspect against and had three breaches: Regulation 9. Person centred care. Regulation 18. Staffing and Regulation 17. Good governance. At the last inspection, there was a manager newly in post who has since been registered with the Care Quality Commission.

At our most recent inspection, we identified improvements in all areas although there were still some concern about staffing levels and whether there was sufficient skill mix on shift. Staff recruitment remained a difficult area for this service and for the care sector in general.

The service is for older people who require residential care, some of whom may be living with dementia. The home could accommodate up to 74 people in single, en-suite rooms. Accommodation was over two floors with the dementia unit on the ground floor. On the day of our inspection there were 70 people using the service.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the home had improved and had worked hard to meet its own action plans. The home was well led and the staff we spoke with were very professional, knowledgeable and provided care centred around the needs of each individual. At the last inspection, we reported on a breach of regulation in regards to staffing levels. At this inspection there were enough staff to provide care people needed in a safe way. However, we saw there were difficulties around the recruitment and retention of staff and agency staff were being regularly used. Ensuring there were staff with sufficient skills and experience was also a challenge for the service given a recent vacancy of unit leader and only a small number of senior staff who could lead and direct the shift.

Staff spoken with were familiar with safeguarding protocols and how to protect people as far as reasonably possible from abuse. The home was proactive in reporting any concerns of alleged or actual abuse. They told us they reported anything of concern and brought it to the attention of the local authority. They worked with other agencies to try to support people with their anxieties and distressed behaviours. We received feedback about this and were told that a consistent approach was not always used and the guidance in people's care plans not always sufficiently detailed to support staff to work in a consistent way. We observed staff and found their approaches consistent and calm in the way they approached people.

Medicines were well managed and people received them as intended. We identified an issue with recording but were given immediate assurances that this would be addressed.

Risks to people's safety were managed well and there were enough staff to deliver care as needed. There was sufficient management oversight of risk. This helped ensure people received safe care and treatment.

Robust staff recruitment processes were in place and helped recruit staff with the right attitude and skills for the job

Staff were supported through induction, training and ongoing support to help develop their confidence and competencies. A lot of staff had transferable skills and qualifications from their country of origin. For staff new to care, a nationally recognised induction, the care certificate, was used by way of introduction and covered all the key skills and competencies.

People were supported according to their preferences but engagement with people, their relatives and staff in the planning of care needed further consideration. Staff acted lawfully in terms of supporting people who lacked capacity to make informed decisions for themselves. Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process.

Staff had sufficient understanding of legislation underpinning human rights, equality and diversity and mental capacity. They demonstrated this through their approach to person centred care.

People were supported to stay healthy and to receive health care as and when required. Staff had an understanding of long-term conditions people had and monitored these so they could identify any changes, which might require medical intervention.

People were supported to eat and drink enough for their needs and there was monitoring of people's weights, which provided information staff could act upon if unintentional weight loss was identified. There were good systems in place but the occasional gap in audits and records could potentially mean that actions taken to support a person would not be timely.

People received care based around their needs and wishes and this was documented. Some restrictions were observed due to available staffing, for instance planned activities were not yet available seven days a week and some people were requesting to go outside and were reliant on staff to facilitate this. We did not observe staff offering to do this. There was no transportation at the service to enable trips to take place. We noted good engagement with relatives but less so with the local community which would enhance people's experiences and help them live well. The activities we saw taking place were good, and increased people's well- being.

Staff were observed enhancing people's health and well- being. They were polite, considerate and knew people well. There was a lovely atmosphere throughout the home with staff supporting each other and providing unhurried, timely care. Care was provided on an individual basis but people had limited opportunities to feedback their experiences. Surveys were used for feedback and issued every six months. Regular relative meetings also took place and some people had good input from other health care professionals. People were involved in their plan of care where they were able. However there were no resident meetings and it was not clear how some people would articulate any concerns or improvements they may wish to see.

The environment had been created to provide stimulation for people living there. The layout helped people

walk with purpose without restrictions. There were areas of interest and lots of tactile objects and things to stimulate people visually. The environment was clean and personalised for each individual. People on the ground floor had access to the gardens and people upstairs could access the garden with support.

There was a robust complaints procedure and other means for people to feedback including regular audits of the service. The director was at the home during our inspection and visited each week and informally audited the service although the outcome of their visit was not always recorded so we could not see what actions had been identified. All the staff knew the director and said they were friendly and approachable.

The home was well-led with most staff expressing confidence with the manager and reporting positively on the changes they had seen. The biggest threat to the service was recruitment and retention of staff especially given the high level of need and supervision required by some people using the service.

There were systems in place to try and continuously improve the service and ensure people's needs were met. We found systems robust but did find gaps in the frequency of audits and found not all records as robust as we would expect. However, we did not see any evidence that this had reduced the quality of service.

The home was well supported by health care professionals and relatives of people using the service. The manager also attended a number of forums and had contact with other home managers in the county. This helped them keep up to date with best practice and share ideas in a mutually supportive setting

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 deliver care to people in a timely way although staff recruitment remained a challenging issue for the service.

People received their medicines as intended and these were administered by suitably qualified staff.

Risks associated with people's welfare and safety were assessed and effectively managed.

Staff understood the importance of safeguarding people in their care and knew how to do this.

There were systems in place to ensure people were cared for in a clean environment and the risk of cross infection was reduced as far as possible.

There were robust recruitment processes to help ensure only suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff were trained, and inducted adequately into their role to help ensure they had the necessary competencies and skills.

People were supported to eat and drink enough for their needs and this was monitored to ensure any unintentional weight loss or inadequate fluid intake could be acted upon.

People were supported as far as reasonably practicable to make decisions about their care and welfare.

People were supported to stay healthy and to access the health care services they needed.

Is the service caring?

Good

The service was caring.

Staff demonstrated warm, caring relationships with people they were supporting.

People received care and support based on their identified needs and wishes.

Care was personalised and took into account people's life experiences.

People were involved in making decisions about their daily care and welfare needs.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and care was planned around their needs.

People were supported to stay active and had opportunity to socialise and join in different activities designed at promoting their well- being and reducing social isolation.

People and their relatives were able to comment on the service and the director and manager took this into account when planning and delivering the service.

Is the service well-led?

Good

The service was well-led.

Changes had occurred within the service and this had resulted in an improved experience for those using it.

The staff took into account people's preferences and wishes and planned the service accordingly.

The manager and director were approachable and led by example. There were systems in place to support and develop staff. The service had tried to recruit enough staff to ensure the effective delivery of care.

Audits were in place as a mechanism for identifying improvements required. However gaps in audits potentially lessened the effectiveness of these audits.

Iceni House

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.

The inspection took place on the 4 October 2017 and was unannounced. The inspection was carried out by a lead inspector, a specialist advisor who was a trained nurse and a bank inspector.

Before we inspected we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events, which the service is required to send us by law. We reviewed the last report and spoke with the Local Authority.

We also reviewed the Provider Information Return (PIR), which the provider had completed. This 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.

At the time of the inspection, we met with the registered manager, the director, and three health care professionals. We spoke with ten people using the service, three senior carers, five care staff, one unit manager, the cook, the activity staff, five relatives and reviewed six care plans. We reviewed three medication records and carried out observations throughout the day including lunchtime, medication administration and activities. We looked at other records relating the running and management of the business.

Good

Is the service safe?

Our findings

The service was last inspected on the 7 and 9 September 2016, and required improvement in all areas. There was a breach in regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. There were not always enough staff to deliver effective, timely care.

At this inspection we saw there were enough staff to deliver individualised and timely care. We looked at rotas, dependency tools and the staff board which correlated with who the manager said should be on duty. They confirmed they had the staff they should have; three were agency staff and the rest permanent staff. Immediately after lunch several staff went on their break at the same time. This left the floor a bit short at a time when a number of people were actively mobile and at least one person was constantly asking to leave.

People and relatives we spoke with felt there were enough staff and they received timely care. People were unhurried and there were different things planned throughout the day. One person told us, "Yes I see regular, familiar staff. "A relative told us, "The staff are well trained and nothing is too much trouble for them."

Staff told us they went the extra mile including coming in on their days off to take people out and to help make continued improvements to the environment such as redecoration. They said staffing levels were okay and all staff felt the current 12 hour shift pattern worked well. It helped ensure people had continuity of care and gave staff additional time off in between their duties.

After our inspection we received some concerns from a relative and a staff member about the skills mix on shift and the fact there was not always someone leading the shift or qualified to give medication. Concerns were also expressed about the high dependency levels of some people using the service and issues of compatibility putting some at risk from the behaviours of others. Concerns were expressed about the number of staff on duty, the turnover of staff and use of agency staff members.

With regards to concerns about insufficient numbers of staff trained to give medicines this was not our experience. On the day of our inspection, there were three staff qualified to give out medicines. The manager told us 15 staff had completed their competency assessment for administration of medication. They reported medication had never been missed and they had on call procedures should there be senior staff absence but said there was always more than one senior.

We spoke to both the manager and the director about staffing levels before and after the inspection. They told us they had worked hard to improve their employment practices to help ensure they employed suitable staff. However they did say recruitment had been difficult and at times they had more staff leaving than joining the service. They attributed this to changes made by the manager in trying to develop a better working culture. Some staff had chosen to leave, others left due to poor performance. The director provided us with their rotas and dependency tool. We saw there was still a shortfall of staffing hours which were being recruited to with some success. Agency staff and overtime meant the service provided the necessary staff cover to ensure people's needs were met.

The director told us that staffing levels had recently been increased due to changes in people's needs. They said more people were being admitted to the home with a primary diagnosis of dementia rather than frailty. This had impacted on the profile of the home which traditionally offered a designated dementia unit on the ground floor and a unit for physically frail people on the 1st floor. The director said they were responding to this challenge by increasing the staff and by providing more training opportunities in dementia studies.

People were protected, as far as reasonably possible, from abuse because staff were trained in recognising abuse. There were clear processes for staff to follow should they suspect a person was suffering from abuse. Staff knew what actions to take to report abuse. A senior carer gave an example of something they had reported in the past and were satisfied that this was responded to appropriately. Contact details for reporting concerns were on display in both staff offices on each floor. The senior carers gave evidence of how they protected people in the home. They said" I look out for signs of abuse for example increased aggression or withdrawal or signs of bruising."

Risks to people's safety were managed well and additional funding agreed when a person's needs changed. Staff worked with other professionals to meet people's needs holistically. Some people using the service had behaviours which could potentially put themselves or others at risk. We observed staff using different approaches to try and support people with their behaviours and anxieties. Staff's approach to people was to provide gentle encouragement and tactile reassurance when interacting with people. This helped to reduce people's anxiety and to stay calm. Staff were skilful in reducing incidents of aggression by diverting people's attention or anticipating their needs before an incident had occurred. We noted that staff presence and interaction with people enhanced their sense of safety and wellbeing. Staff did not rely solely on the use of antipsychotic medication or sedatives. The home had been successful in the case of one person of taking them off all their medications in relation to their behaviours.

We reviewed a sample of care plans including those of people with complex needs. We found risks were clearly documented and showed actions staff should take to reduce the risk. Staff showed a good understanding of people's needs and risks associated with their care. Records included a medical assessment, list of medicines, a body map showing any marks, abrasions or bruising to the skin, a skin integrity assessment and associated plan in relation to this and manual handling plan. We also saw nutritional assessments, continence assessments, dementia assessments and specific plans around foot care and mouth care. Assessments were kept under regular review but some gaps in the reviewing schedule were noted. We noted people receiving care in a safe environment and staff regularly checked on people to try and help promote their safety.

Medicines were managed safely and given to people as the prescriber intended. Medicines were checked on both units and we looked at the practices for safely managing controlled drugs. The manager had recently introduced another book for recording the quantities to enhance safety. On the day of the inspection, all the controlled drugs were accurate and the records had been signed and dated. The records of medications for disposal were signed by two members of staff.

Staff administering medication had been trained to do so and their competency assessed through a series of observations. We saw evidence of this in staff files. There was a list of staff's signatures of those who were able to administer medication.

There was evidence that medication audits were being completed to ensure people received their medicines as intended. Medication administration records were signed correctly and tallied with the checked stock. We observed the medicines being administered and this was done appropriately in the morning. The lunch time medication was administered after lunch, which meant all staff were available to

support with the lunch time meal. Staff ensured they administered the medication as safely as possible but we identified one person using the service becoming quite upset and interrupting the staff administering medication. This could have resulted in an error being made and the floor was short of staff as two had gone on their break. We spoke with staff about administering medication and they said they took their time to do it properly. Seniors told us some of the care staff had been trained so could help administer medication as there was more than one trolley on each floor. We also noted that a carer signed the MAR chart prior to the administration of medication. We discussed this with them as they were not following the correct procedures as laid out by the medicines policy. This was brought to the manager's attention so it could be addressed with all staff.

There were enough staff employed who had been properly recruited to help ensure people received safe care. Staff recruitment files showed there were necessary checks in place to ensure staff were of good character and meet the homes shortlisting criteria. Staff completed an application form showing previous work history and also obtaining references, proof of identify, address and eligibility to work in the UK. Records in relation to disclosure and barring were sought before employment to ensure staff did not have a criminal record which might make them unsuitable to work in care. All those involved in recruitment understood the importance of these checks.

Good

Is the service effective?

Our findings

The service was last inspected on the 7 and 9 September 2016 and was rated requires improvement in all areas. There were no breaches identified in this area.

At this inspection, we identified improvements had been made. Staff received training appropriate to their role. The staff we spoke with were sufficiently knowledgeable and competent. Some had worked in similar caring roles and had transferable skills. They told us they had regular opportunity to update them. Some staff had or were supported to do additional care qualifications. Staff who were new to care completed the 'Care certificate'. This is a nationally recognised competency based induction which provides a foundation course for new staff. Staff said they received regular support and one to one supervision, team meetings and annual appraisals of their performance.

We interviewed a number of health care professionals who knew the home well. They described the staff on the dementia unit as 'supportive of the residents'. One professional said in regards to a senior. "Marvellous, they know their stuff."

The senior carers reported that they were supported to do training and their mandatory training was up to date. Staff reported training was made available depending on the identified needs of people using the service. This included training in dementia care, diabetes and specific nutritional needs. Health care professionals we spoke with felt staff were sufficiently knowledgeable and had information to hand.

Staff induction, which was extended to agency staff, consisted of a period of shadowing more experienced staff. When new staff commenced at the home, they received a week's induction period and were required to complete an induction book with support from a senior staff member. This provided new staff members with the knowledge they required to work safely within the home. During this time, staff were also allocated to work with another member of permanent staff who they 'shadowed' on the floor. This enabled staff to familiarise themselves with the environment and their work space. This applies to all staff across the home whether they were carers, domestic assistants or kitchen staff. Regarding care staff, they undertook all care with the support of an experienced team member. Care delivery was covered throughout the induction period. We saw that some staff had considerable experience within Iceni House and within the care sector and were therefore appropriate mentors. Other staff had transferable qualifications and skills to work in the care sector. Some staff had specific areas of responsibility for key areas of practice such as infection control so they could take extra responsibility and act in an advisory capacity to other staff.

We spoke with a member of staff recently recruited about their initial induction. They told us, "I was shadowed, and have been supported by senior staff they have been fabulous and very supportive and always check what I am doing."

We observed staff acting lawfully to support people with decisions about their care and welfare. The Mental Capacity Act 2005 (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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

There was evidence in people's care records that deprivation of liberty safeguards (DoLS) assessments were being completed although there was no evidence in the records that the applications had been processed by the local authority. This is not uncommon at present as there is a long delay in the processing of applications.

We observed staff asking people for their consent before providing care. For example people were asked if they would take their medication and asked if they wanted pain relief. They were asked to join others for lunch and asked what their preferences were and if they wanted more to eat. There was evidence in the records reviewed that consent was being obtained for flu vaccinations and that relatives were being involved in care planning.

People were supported to eat and drink enough for their needs and wishes. Staff closely monitored this so they could respond to any unplanned weight loss or loss of appetite and fluid intake. There was evidence in the records reviewed that weights were being regularly recorded. A person who was recorded as having suffered from weight loss had been prescribed build up drinks and the records had recorded an increase in weight to their original recorded weight. There was evidence that referrals were being made to the dietician service and the Speech and language team (SALT) for persons who had difficulty swallowing for assessment. A person was receiving a pureed diet. The cook reported that they were able to meet people's dietary needs and had a good understanding of people's needs and any specialist diets.

A relative reported that the food was very good. One person stated that they enjoyed it and that the service provided them with good care. One relative told us that their family member had a lot of urine infections before moving into the service as they did not drink enough. They said since being here they had not had one as they now ate and drank well.

We carried out observations at lunch time on each of the units, and separate dining rooms. People's choices were mostly promoted but some staff when asked did not know what the menu choice was until the trolley arrived. Staff gave people a choice and a number of people had a choice not on the main menu. One person did not want the food and had told us previously they did not like the food and found it repetitive. However, staff went to great lengths to encourage them to have their meal and establish where they would like to eat. They agreed to eat an alternative which was acceptable to them.

We observed staff serving meals to people in their rooms. Staff were friendly and cheery and offered options which were then plated up from a warm trolley in the corridor. A care staff assisting a person to eat did so gently encouraging and presenting food in small forkfuls. They were chatting in a friendly way and offering options e.g. if person would like some tea. They ensured the person was in a comfortable position in bed that helped avoid a choking risk. Senior staff noted for one person their room was a little cold and immediately with the person's consent put their heating up.

We observed juice being handed out to people but some people were not offered or did not have a drink to hand and either had to ask or went without. Several people said they enjoyed an alcoholic beverage and it

was not clear if this was offered. The seating arrangement for some did not appear to always take into account people's needs. For example, some people got on well but others sat in silence. One person was rude about the person they were sitting next to. There was no background music.

One person stated they preferred to eat in their room and their wishes were upheld. Two carers who had been delivering meals to people in their rooms joined at the table and provided discreet assistance and friendly encouragement. We observed friendly chat, which included all the people at the table. People have access to food, drinks and snacks throughout the day and the senior carer on the downstairs unit was seen to be providing tea on request. Fluid and nutritional charts were being recorded and showed good intake and output was also recorded when appropriate.

People's health care needs were being met. There was evidence in the records reviewed that people with diabetes were being assessed and receiving both visual care and input from the chiropodist service. We spoke with a number of health care professionals, one of whom said the home was one of the best in the area and they regularly visited and had no concerns. Another named a number of staff who they said were very knowledgeable.

There was evidence that there is good liaison between the care home and the Mental Health Team and the crisis team. . The Mental Health Nurse reported that staff were 'always pleasant and happy to try different approaches'. There was evidence in the records reviewed that referrals were being made to the Community Matrons, GPs, SALT, Dieticians and the District Nurses. A person with an indwelling catheter was being seen by the district nurses for his catheter needs.

Records included a hospital passport, which could be transferred with the person if they required a hospital stay. This included essential medical information but did not document people's social care needs or care preferences. There was also a document entitled "planning ahead" which took into account people's wishes should they become frail, end of life or need hospital admission. This helped the service to anticipate and plan for people's future. Where these were in place information had not always been recorded and this was something identified by the provider.

The environment had been sufficiently adapted to meet people's individual needs. The care home was purpose built and is in good repair. It had recently been refurbished and the staff had given different areas different themes. The dementia unit had a homely feel and people had personal belongings in their rooms. There were railings along the corridors; however, they lack tactile markers to help visually impaired people determine the end of the railings. There was a secure dementia unit, which had keypad access. It also had a 'book corner' with a fish tank, a separate relatives' tea room which had secure access and information for relatives. Some walls were themed e.g. beach theme in corridor with tactile objects as well as painted walls, a sewing area. We also saw a music theme with instruments securely attached to wall. Newspaper headlines on the wall and a sensory wall. The assisted bathrooms were well equipped and decorated really well. There was a 40s 50s themed sitting room with access to small secure garden.

Good

Is the service caring?

Our findings

The service was last inspected on the 7 and 9 September 2016 and was rated requires improvement in every area. There were no breaches identified in this area.

At this inspection, we identified improvements. Staff had developed positive, caring relationships with people using the service. All staff were observed interacting with people with warmth, kindness and compassion. People received timely care based on their needs and wishes. Care and support was unhurried creating a relaxed atmosphere throughout the home. We saw staff interacted well with each other and people they were supporting and were cheerful with lots of laughter in a calm atmosphere. A few staff said at times people could show aggression but they felt able to respond appropriately. They said some staff were better with some individuals than others and they worked to each other's strengths.

We spoke with staff, one said, "I love this place, we are like a family, we care for each other. " We spoke at length with a relative whose family member had recently moved into the home and whose needs had changed dramatically prior to admission. They told us how well they had settled. They said they were doing things they had not been doing at home such as eating and drinking better and said it was a testimony to the staff. They told us, "The home is brilliant, I have no complaints." They went on to say, "They were lucky to be here." They were visibly upset, staff acknowledged this and spent time talking to them which helped them deal with this difficult separation.

One person spoken with described it as a "Rolls Royce service," when comparing it to another home they had temporarily stayed in.

The senior carers reported that they give people choices to meet their individual needs. We overheard care staff chatting to people and engaged regularly with people e.g. asking 'What would you like to do' offering to get a cup of tea. The domestic staff member offered a cushion for one person to make their seat more comfortable. The senior was observed explaining to people about what medication they wanted them to take. They skilfully communicated with people using clear language. All staff were observed speaking appropriately to people and taking time for people to respond. Throughout the day staff checked on people, spent time with them and maintained suitable eye contact. We looked at people's records which confirmed staff were supporting people according to their needs and wishes.

Records recorded people's individual likes and dislikes and preferences. Examples included 'she likes the window open', 'likes to be smart', 'likes to wear make- up.' Records also included 'My History', interests and hobbies and food preferences.

Staff were respectful. For example the manager took us around initially and stopped to introduce us to people using the service and visiting relatives. Where people wanted attention this was provided immediately. Another example was a staff member needed to get past a person in their wheelchair. They asked their consent to move the chair forward and gave them time to respond. Staff took every opportunity

to engage with people as they walked past. At lunch people were supported discretely at their pace. We observed staff were respectful. For example,

We observed during planned activities the staff supporting the activity were inclusive and people supported and praised for joining in. We noted at lunch time staff served cherry pie. This sparked a conversation about puddings people used to make and enjoyed. One person said they liked spotted dick and staff established how they used to make it.

People were actively involved in their care. There was evidence in the records reviewed that people were being involved and have been asked to express their views in making decisions with regard their care, treatment and support. When people have been assessed as not capable of making their own decisions the care staff had recorded the views of family members. A relative interviewed reported the staff 'involve me in the care plans and I sign the paperwork'. However, there were no resident meetings and some people were hard to engage in terms of giving feedback about their experiences. There were observations of care but these tended to be informal and not recorded.

People received dignified care and their privacy was respected. On the day of the inspection, staff ensured that doors were closed before giving personal care. People were seen to be clean and appropriately dressed. One relative told us, "The staff are lovely, they give my husband a shower and he is always clean.'

However, another relative expressed some concern about the levels of care provided particularly in relation to eye care. We referred these concerns to manager as they were received after the inspection. However during the inspection we did see reference to eye care in people's notes.

The home had areas where relatives could go if they wished and make themselves a drink and or snacks. This was the same for people using the service and meant relatives could meet their family members in private or simply take some time to themselves. There was information around the service to help relatives know what was going on in the service and to help them feel involved. Staff were wearing names badges so that people and relatives would know who was who. There was also a staff board showing who was on duty and who was in charge of the unit should relatives need to raise anything.

Good

Is the service responsive?

Our findings

The service was last inspected on the 7 and 9 September 2016 and was rated requires improvement in every area. There was a breach of Regulation 9: person centred care. People were not always receiving the care required for their needs. During this inspection we identified improvements had been made. People received care which reflected their needs and preferences. Staff were observed as being responsive to the needs of people on the unit and were seen to respond to requests and ensure the comfort and safety of people. They were observed to be kind, warm and compassionate.

We spoke with people and relatives who were happy with the way their care was provided. One relative told us, "Staff are really nice, and we see familiar faces, there are some exceptional carers." They went on to tell us about the different activities and events within the home. A relative reported that the staff are 'marvellous, they are just like a family to me.' One person on our introduction invited us to see their room. They said they were mostly independent but said staff did always check they were alright.

People's interests and past history were recorded in their records to help staff plan care around their individual needs. We observed people joining in an activity which was well received and people were reminiscing about the past. Another activity which was inclusive involved a general knowledge quiz. People were given the right amount of support to join in. We also observed a music session in the afternoon and staff were seen to join in and encourage people to. One person chose not to join in but sat reading his paper and clearly enjoyed the interactions around him.

We spoke with the activities co-ordinator who told us about the programme of activities they tried to provide alongside another person who provided activities. They stated they hoped to extend activities from five days a week to seven and were currently advertising for this. Activities included a cream tea on a Friday, Pets as therapy, flower arranging, reminiscing, quizzes, arts and crafts, outside entertainers including recently "zootastic." This is a mobile zoo where small animals and reptiles are introduced to people to hold and discuss. They told us they had a budget for activities and did fundraising. They said the director was generous and would even give money for people to get ice cream from the ice-cream van. They said there was a two-week programme and it was made up from people's suggestions and activities evaluated to see if they were worth repeating.

One person told us they got bored as a lot of people were less independent and said they could not go out in case they got run over. We asked them what activities they might be interested in and they told us they 'liked the pub, and a shop and a gentleman's club where they could have a beer and play darts." They said there used to be a shop but it did not come round anymore. We shared their ideas with the activities co-ordinator who agreed that gender specific activities would be a good idea. The service had a range of activities for people and some community inclusion but would benefit from some volunteers and increased participation with the local community and being able to offer trips out.

The environment was cohesive to people's well- being. We saw one of the lounges had access onto an internal courtyard with a sensory garden and wind chimes. We saw a person going out independently to the

garden and another we were told regularly left the service to go into town. We saw the service was carefully arranged to help people find their way round and be able to walk with a purpose without encountering locked doors. There were areas people could stop and rest, enjoy quiet time or socialise with each other. There were areas of interest and objects on the wall providing sensory stimulation. In one corner of the home, there was a basket of clothes and a washing line. The manager told us people would often hang clothes on the line or take them off and fold them up. This helped people stay engaged and repeat activities they were used to doing.

Care files were well organised and comprehensive, with person centred care evident. Documents were mostly completed. There was some evidence of reviews being planned and carried out but this was not consistent and was an area for improvement. We reviewed six care plans and found that there was a one page summary of people's main needs in their rooms. This enabled staff unfamiliar with people's needs to have a brief overview of their main needs and support they required. The information recorded in people's care plans was consistent with what staff told us. Staff people knew people well and responded well to people's needs.

People had personal care records in their rooms. These records reflected care they should have and had received daily or as required. These records also reflected individual wishes and consent for care. The records reviewed also had evidence of people's individual preferences, likes and dislikes and how they wish to receive personal care. A relative reported that they had been involved in the decisions regarding their husband's care

We met a person with complex needs and observed staff were skilful in engaging them in activity and in accepting personal care. There was support in place to promote their well-being and promote positive mental health. Staff knew about their needs and how past trauma had affected their life. We found their care plan a little limited in some respects as it did not tell us what might trigger a poor mental health episode or if there were any strategies which were found to be effective. This might help staff anticipate this person's mood in advance.

The complaints procedure was evident throughout the home and people and relatives knew and felt confident in raising concerns. Concerns had been raised about the laundry and one relative told us they had complained about the cleanliness of their family member's room. However, they said this was resolved immediately. There were written records to support this and every one told us how supportive and responsive the manager and director were.

The director kept abreast of safeguarding concerns raised through the complaints procedure and often reviewed complaints personally. They gave us an example of a safeguarding concern which had been raised by family and resolved. The outcome had been shared with staff to help inform future practice and bring about improvements.

Good

Is the service well-led?

Our findings

The service was last inspected on the 7 and 9 September 2016 and was rated requires improvement in every area. There were three breaches identified including one for Regulation 17 good governance. We found the director did not have effective systems and adequate processes to assess and monitor their service. Following the inspection the director sent us their action plan as required. We used these during our most recent inspection to check progress against areas of concern identified at the last inspection. We found the director and manager had worked hard and had made significant progress in improving its service and had more robust systems to measure its performance.

During this inspection, we identified no concerns about staffing levels but did receive some concerns about this following the inspection. We received a robust response from the manager and the director. They told us how they ensured they had the correct staffing ratios for people needs by seeking informal and formal feedback from staff and unit managers. They also had regular meetings with relatives and used feedback forms to identify any concerns or shortfalls in provision.

They said they monitored the time taken to complete medication rounds and completed call bell audits looking at average response times which they expected to be answered within two minutes or less. Anything over this was investigated to find out the reasons. Individual dependency assessments were in place to calculate the amount of support a person was likely to require and this was kept under review. We viewed the call bell audits, dependency tools, staff rotas and feedback about the service. On balance, we were satisfied that current staffing levels were satisfactory and both the director and manager had worked hard to increase staffing and improve the quality of care provided.

We received some concerns following the inspection. We sought more assurances about the culture of the home. During our inspection one health care professional commented on the staff's ability to support so many people with complex needs and said they had noted differences between the two floors in terms of how staff managed situations for people with high needs. They described the attitude of some of the staff in the upstairs unit in regard to a person as 'derogatory'. We discussed this during out feedback and the manager said they would address this with all staff. Most staff expressed high levels of job satisfaction. They were able to tell us how many improvements had been made since the last inspection.

After the inspection the manager and director told us they operated an open-door policy and welcomed feedback from staff and people using the service. Formal feedback from staff was sought through staff team meetings led by unit managers, attended by the manager and on occasion by a director. These were minuted and viewed by the inspectors. Staff supervisions were conducted by the unit managers or departmental heads. These were viewed and actions in terms of staff training and development noted. There were formal processes through which staff could escalate concern up to director level. The director told us they were working on implementing an online survey using 'Survey Monkey' to allow anonymous feedback from staff. This will be operational next month.

The home had a zero tolerance to bullying within the home, which all staff were made aware of. The service

has a whistle-blowing policy, which was included in the staff handbook as well as in the policies and procedures files, located in each unit, as a guide and reference. The manager said any allegation of bullying was dealt with through supervision and mediation and has only been highlighted once since being in post.

The manager had been in post since the last inspection and was registered with the CQC as required. They had worked hard to improve the service both by improving the culture within the home, and the environment in which people lived. All the senior carers reported that there had been 'an enormous improvement in the management of the home'. A senior carer stated there had been a "…dramatic change…" and two senior carers reported that care was now 'more person centred.' One staff member described the manager as, "Incredible and the right person to lead the home." A relative told us, "My spouse is being well cared for in the home. The home is especially good, with a good manager." One staff member told us, "The senior staff empower the care staff to take responsibility, I love my job."

The manager told us they had strengthened the recruitment procedures to try and attract and recruit staff with the right attitudes and values. They said they had supported existing staff to improve the overall care provided. They said they were supported by the director who was there every week and supported them well. The manager in turn said they supported their staff and currently had one unit leader who they said they worked well with. In terms of staffing, they said they recognised the staff team's hard work and there were financial incentives for staff that went the extra mile. They said they were looking to enter the regional and hopefully through to the national care awards which recognised the individual and organisational contributions they make to care.

Throughout the day, we saw care was well planned around the individual needs of people using the service and care plans provided good insight into people's needs and how they should be met. The only concern we identified was that records, although extensive, were not always reviewed when they needed to be. For example, we looked at medication audits, falls and weight records, care plan audits and cleaning schedule audits. We concluded that, when audits were completed, they captured relevant information which was then acted on. However not all audits were consistently carried out and we found the occasional month when the audit had not been completed. We also found variations between units and the frequency of audits and concluded this might be down to recent changes within the senior team. However, we could not see that these gaps had been identified by the Director during their regular visits. We did not identify a significant impact from this but were concerned as there had been a previous breach of Regulation 17: Good governance. We were assured by the provider and the manager that they would continue to improve and strengthen their auditing processes

We had discussions with the Director who told us they were closely involved in the home and this was confirmed by staff and people using the service. They told us they attended some planned staff and relatives meeting. They were keen to emphasise that open communication was key so mistakes or poor practice could be brought out into the open, discussed and learnt from. They gave examples of lessons learnt and how they were continuously trying to develop the service and improve the quality of care they were providing. The director said they had four homes and learning was shared across them and managers were equally supportive of each other.

Although the director had a really good understanding of the issues within the home, they agreed they had not identified some of the gaps in record keeping we had picked up; neither did they clearly record their findings when carrying out quality audits. This would help demonstrate the effectiveness of the service and changes made. The director told us they had a lot of confidence in the manager and the manager in him. This was echoed by the staff we spoke with and we saw attempts at trying to develop the staff team and particularly the management roles to try and foster an inclusive service which functioned well whether the

manager was or was not there.

Relatives' meetings were held regularly and were well attended. They were held at different times across the day to help those working or with other caring responsibilities attend. Relatives spoken with told us they had been involved in their family members' care when appropriate. Six monthly reviews were established to ascertain people's feedback or their representative's views. We viewed a sample of these and these were appropriate.