Broadening Choices For Older People

Anita Stone Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place with an unannounced visit on the night of 05 April 2017 with return announced visits on the 06 and 11 April. This was the home's first inspection since registration in May 2016.

Anita Stone Court provides accommodation over three floors for up to 33 people who require nursing and/or personal care. Some people have complex medical conditions and some people are living with dementia. At the time of our visit 32 people were living at the home.

Although there was an interim manager providing operational support at Anita Stone, there was no 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. However, the provider had recently appointed a new general manager and explained their intention was to submit an application once they had completed their probationary period.

Risks to people were being monitored with care plans and risk assessments being reviewed monthly, however reviews were not always consistently completed. The interim and deputy managers carried out audits and checks to ensure the home was running properly to meet people's needs and to monitor the quality of the care people received but the audits had not identified some of the issues we had recognised during the inspection.

We saw most of the staff interacting with people in a friendly and considerate way and that staff respected people's choices. People were generally supported by caring and kind staff who demonstrated a positive regard for people's privacy and treating people with dignity and respect. Although this was not consistently practiced by all staff with some unsuitable comments being made and actions observed.

People living at the home and their relatives told us they felt the home was a safe environment for people to live in. Staff spoken with could identify the different types of abuse and explained how they would report abuse. People were protected from the risk of harm and abuse because staff knew what to do and were effectively supported by the provider's policies and processes.

We saw all staff were busy but were available to provide support to people when needed. There were differences of opinion as to whether there were sufficient numbers of staff employed by the provider with some people, relatives and staff saying there was not enough staff whilst others felt there were sufficient staff numbers to provide support to people. Staff supported people to eat, drink and move around the home safely. We saw that requests for assistance from people were responded to promptly. We found the provider's recruitment processes ensured suitable staff was safely recruited.

Peoples' care records contained information relating to their specific needs and there was evidence that the

care plans were updated when people's needs changed although there was some inconsistency when reviewing people's weights. Some people living at the home and their relatives told us they were involved in developing and reviewing their care plans. Staff understood how to seek consent from people.

People received appropriate support to take their prescribed medicines and records were kept of the medicine administered to people. Medicines were stored securely and consistently at the recommended temperature given by the manufacturer and were safely disposed of when no longer required.

People were assisted by suitably trained staff that told us they received training and support which provided them with the knowledge and skills they needed to do their job effectively. People and relatives felt staff was knowledgeable on how to support people effectively and that staff possessed the necessary skills.

We found mental capacity assessments had been completed for people who lacked the mental capacity to consent to their care and welfare. The provider had taken suitable action when they had identified people who did not have capacity to consent to their care or treatment. Applications had been made to authorise restrictions on people's liberty in their best interests.

There were a mixture of opinions and views from people and relatives around the quality of the activities and interests being offered. We found the provider had employed permanent staff to develop activities, hobbies and interests with people, with plans to recruit an additional two staff to ensure peoples' hobbies and interests were encouraged and maintained seven days a week.

Some people told us they had no complaints and were confident if they did, that the provider would deal with it effectively. A number of relatives told us they had made complaints and we found they were investigated and resolved to the satisfaction of the complainant, with one complaint currently being investigated.

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

People told us they felt safe. People were safeguarded from the risk of harm because staff were able to recognise abuse and knew the appropriate action to take.

Risks to people's health and safety had been identified and were known to the staff. This ensured people received safe care and support.

People were supported by sufficient numbers of and suitably recruited staff.

People were supported by staff to take their medicines as prescribed by their GP.

Is the service effective?

Requires Improvement

The service was not always effective.

There were arrangements in place to ensure that decisions were made in people's best interest. Staff sought people's consent before they provided care and support.

People were supported by suitably trained staff.

People did not always enjoy their dining experience and the food they were offered. People were given refreshments at regular intervals, or when requested. People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration, although there was improvement required in the way people's weight was being monitored and recorded.

People received support from healthcare professionals to maintain their health and wellbeing when it was required, although advice given to the provider was not consistently followed.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was generally maintained but this was not always consistent with some staff practices.

People were largely supported by staff that was kind and respectful, but this was not consistently applied by all staff.

People's independence was promoted as much as possible and staff supported people to make choices about the care they received.

People were supported to maintain relationships with their friends and relatives.

Is the service responsive?

Good

The service was responsive.

People received care and support that was individualised to their needs, because staff were aware of people's individual needs.

People knew how to raise concerns and were confident the provider would address the concerns in a timely way.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although some processes for evaluating individual records had not ensured the information had been consistently reviewed, the provider had identified this as an area for improvement and plans had been introduced to address this.

Quality checks to assess and monitor the quality and health and safety of the service were completed by the provider. Where areas of improvement had been identified through an audit, an action plan had been put into place.

People were generally happy with the care and support they received and the provider sought the opinions from people, relatives and any visitors to the home.

Anita Stone Court

Detailed findings

Background to this inspection

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

We had received information of concern about the number of staff working at the home, particularly at nights and weekends. This inspection took place over three days. The first unannounced night time visit on 05 April 2017 with two announced visits on 06 and 11 April. The membership of the inspection team comprised of one inspector on 05 and 11 April and one inspector, an expert by experience and a specialist advisor on 06 April. An expert by experience is a person who has personal experience of using or caring for someone living with dementia. The specialist advisor was a qualified nurse who had experience of working with older people living with dementia and/or mental health difficulties.

Before our inspection, we asked the provider to complete a Provider Information Return (PIR). 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. The PIR was returned within the required timescale. As part of the inspection process we also looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications. We reviewed the notifications that the provider had sent us, to plan the areas we wanted to focus on during our inspection. We reviewed regular quality reports sent to us by the local authority to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase on behalf of people.

As part of our inspection we spoke with 11 people, six relatives, the interim manager, the new general manager, the deputy manager, an external consultant and 10 staff members that included nursing, care, kitchen and domestic staff. Because a number of people were unable to tell us about their experiences of care, we spent time observing interactions between staff and the people that lived there. We used a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at records in relation to five people's care and five medication records to see how their care and treatment was planned and delivered. Other records we looked at included three staff recruitment and training files. This was to check that suitable staff was safely recruited, trained and supported to deliver care to meet people's individual needs. We also looked at records relating to the management of the service and a selection of the provider's policies and procedures, to ensure people received a quality service.

Good

Is the service safe?

Our findings

People who were able to give us their views told us they felt safe and liked living at the home. One person told us, "I feel safe that I sleep with the windows and doors open, I'm quite happy." Another person said "We're very safe, looked after by a lovely bunch of carers who go above and beyond." Another person explained, "No, there's nothing to worry about." Relatives we spoke with felt their family members were happy and were satisfied with the care and support being provided. One relative told us, "[Person's name] is most definitely safe here, it's an excellent home." Staff explained to us about the different types of abuse and what action they would take if they suspected someone was at risk of being abused. One staff member told us, "I wouldn't hesitate, I'd go straight to the senior, the nurse or the Chief Executive Officer if I had to and if they didn't do anything I'd go to CQC (Care Quality Commission)." All the staff we spoke with was confident that any concerns they raised would be acted upon and if they needed to, they would escalate their concerns as necessary. Another staff member said, "I've never seen or heard any inappropriate behaviour or comments from staff but if I did I'd report it straight away." The provider had procedures in place that showed when a safeguarding incident occurred appropriate action was taken. For example, referrals would be made to the local authority. We saw the provider had conducted investigations, where appropriate and had worked with the local safeguarding team to ensure people remained safe. The management team and staff understood their responsibilities to keep people safe from risk of harm.

There were a number of people living at the home who were not able to tell us about their experience. We saw that people looked relaxed and comfortable in the presence of staff and that staff acted in an appropriate manner to keep people safe. For example, where appropriate, staff ensured people had their walking frames close by to support them to walk and reduce the risk of falling.

We found people had assessments in place that related to risks associated with receiving care as well as risk assessments in relation to their specific health needs. For example, moving and handling, falls, personal and continence care. We also found there were risk assessments in place that were more specific to people's individual health and care needs. A number of people had been identified at risk of developing sore skin. We saw pressure relieving equipment was available, for example pressure cushions on lounge chairs and wheel chairs and air flow mattresses were in place to support people. We saw there were body maps in place that identified where protective barrier cream should be applied to help heal and protect the skin. Where applicable, referrals had been made to the appropriate clinical professionals.

Safety checks of the premises and equipment had been completed and was up to date. Staff explained what action they would take in the event of a person choking or if there was a fire. The provider safeguarded people in the event of an emergency because they had procedures in place and staff knew what action to take.

Before the inspection we had received information through our website about low staffing numbers, particularly at nights and the weekends. Two people living at the home and staff members had expressed some concern over staffing numbers. Two relatives also shared with us their concern that, on occasion, when they had visited there were no staff available to support people and they had to 'seek out' staff to

assist people. One person said, "My main concern is that in the evening the lounge is left unattended for long periods and there are residents who are wandering around, it's important that someone's always around." We found there was one occasion during the afternoon of 06 April when staff was not visible in the small lounge area for 20 minutes. Although no-one during this time required any assistance, had somebody in the small lounge needed urgent support due to a fall or risk of a fall, there would have been a delay in a staff member being able to respond. Another person told us, "I'm always up late, 8.30am would be fine but sometimes it's not till 10.00am, they [staff] tell me they can't get me up now because they have others to get up first who have more wrong with them than me, it can't be helped I suppose, they [staff] do their best." A staff member explained, "It is busy in the mornings as most people require the support of two staff and it can take a lot longer to get people ready." We spoke with the interim manager and they told us there had been a number of staff who had recently resigned and confirmed staff members had also raised their concerns in team meetings. In response, the interim manager told us that they had increased the number of staff on duty at night from four to five and an additional two care staff, from seven to nine for the morning (am shift) staff spoken with confirmed that this had occurred. One staff member said, "There has been a gradual improvement since [interim manager's name] arrived and I think there is enough staff now we just need a better routine." The management team told us their current staffing numbers reflected the dependency levels of people within the home. They continued to explain the issues around staff numbers related more to how the staff were deployed and the layout of the building. There was an agreement within the management team to review how staff were being organised. We found there were the required numbers of staff on duty and when people required support, staff responded in a timely manner.

We spoke with staff who confirmed that prior to starting at the service pre-employment checks were carried out. We found that included criminal checks through the Disclosure and Barring Service (DBS). The DBS check helps employers to make safer decisions when recruiting staff and reduces the risk of employing unsuitable people. We saw that checks were also carried out to ensure that nurses were registered with the Nursing and Midwifery Council. Records we looked at confirmed the provider had completed employment checks that also included employment and character references.

The Provider Information Return stated that all medications were only administered by nurses and medication audits were carried out on a monthly basis. People we spoke with told us they had no concerns about their medicines and they received their medicines on time and as prescribed by the doctor. One person told us, "The nurses are very good, they explain to you what the pills are for." We saw nursing staff complete a medicine round and saw that they waited with each person to ensure the medicine was taken properly. We saw that nursing staff asked people, who were prescribed medicine to be taken 'as and when required' if they wanted their medicine. We saw medicines at the home were stored safely and securely. An audit of some medicines showed the amount of medicine in stock balanced with the amounts recorded in medicine records; apart from one medicine where the amount left in stock differed from the amount recorded. We found this to be an administrative error and not a medication error. Temperature checks for a fridge that contained medicine had been carried out and these were in line with required temperatures to maintain the effectiveness of the medicine. The nursing staff was responsible for administering and auditing medicines and completing the Medical Administration Records (MAR) sheets.

We reviewed six people's MAR sheets and found that protocols were in place to provide guidance for staff when they were required to give medicines on and 'as and when required' basis. For example, when people required pain relief or became distressed. Although the information included in these was limited the nursing and care staff gave us examples of the signs and behaviours that people would exhibit that meant they required their medicine. We found where people required their medicine to be administered through a skin patch; there was a system in place to ensure the patches were not repeatedly placed on the same area of the body. Changing the position of the patch is important because the adhesive can be an irritant and

make the skin sore, red and itchy. Changing the position of the patch regularly means that the placement area that may be irritated is given time to recover.

Requires Improvement

Is the service effective?

Our findings

There was some difference of opinion on the quality and choices of food made available to people. People we spoke with told us and we saw they were offered choices at meal time and had access to drinks and snacks throughout the day. One person told us, "It's quite good [food] and there is enough." Another person said, "Sometimes there's not much, the other day we had poached eggs on dumplings, it wasn't very nice." Another person said, "I'm not sure what's happened, I think we have a new chef and there has been some improvement." We saw that the lunchtime experience was not consistent over the two days we were at the home. On the 06 April, found the staff were not well organised while lunch was served to people with one person being ignored when they asked for a cup of tea and others being told to eat their food without being actively encouraged. One person told us, "My baked potato was cold and the chicken was too spicy." We saw that plates were taken away quickly after people had stopped eating and people were not being asked if they wanted more to eat.

The experience on the 11 April had significantly improved. Staff were organised with some staff sitting at designated tables to support people who required additional assistance to eat and drink. Staff actively encouraged people to eat saying, "Just try a little bit if you don't like it I can get you something else," "Have you eaten enough, is there anything else you would like," and "Is everyone happy with their meal, is there anything else we can get you." Although the dining area was congested, the atmosphere remained relaxed with conversations between people and visiting relatives were sitting with their family members. We saw people were eating their choice of meal; one person had requested a particular plate of sandwiches that was not on the menu and others asked for hot and cold drinks of their choice and received these without delay. The food looked appetising and was well presented and many people appeared to be enjoying their meals. We discussed the differences we had seen over the two days with the interim manager. We were told there had been issues with the catering and dining experiences and in response to these concerns a new chef had recently being employed and a staff member had been appointed a 'dining experience champion' who had visited the provider's other homes to see how their dining experiences differed from that at Anita Stone. The management team assured us they were continually working with staff to ensure the dining experience remained consistent for everyone living at the home.

We saw the provider used assessment tools to understand how to plan people's support around their nutrition and dietary needs. Staff we spoke with confirmed people was assessed to meet their individual dietary requirements that ensured people received a healthy and balanced diet. We saw that people's dietary needs and preferences were recorded in their care records and, where appropriate, their food and fluid intake was monitored and reviewed. We spoke with the catering staff and they were able to tell us about the dietary requirements of people living at the home.

We found that most people who had been identified as at risk of losing weight had input from clinical professionals, for example, dieticians. Although where considerable weight had been lost; we could not consistently see what further action had been taken, for example a referral to the GP to assess and account for the weight loss. We found there were inconsistences in the weight recordings we reviewed. We saw additional food supplements to sustain and improve people's weight were administered as prescribed and

peoples' weights were monitored. However, one record showed on admission one person weighed 65kgs, a week later weighed 49.8kgs. There were anomalies with other people's weight records. We discussed the anomalies with the interim manager; they explained it could be the scales or the way people were being weighed and told us they would have the scales checked and if necessary replaced and monitor weights more closely with referrals to be made as appropriate.

Visiting clinical professionals attended to people to assess and review the person's care and support needs. For example, GP's, podiatrist, tissue viability nurse, opticians and social workers. People told us if they felt unwell they were seen by the GP. One person said, "I don't see the doctor very often but if I feel poorly they [staff] will always call them [doctors] for me." A relative told us, "Mum's foot became very swollen; the staff were quick to get it seen to." Staff spoken with was knowledgeable about peoples' care needs and how people preferred to be supported. We saw from the care plans we looked at that people were supported to maintain their health and wellbeing with additional input from clinical professionals. We saw that advice given by clinical professionals was not always followed. For example, we saw the provider had been advised by a clinical professional to ensure a pressure relieving mattress was set correctly to the person's weight. We checked the weight recorded for the person against the weight set for the mattress and found a difference of 27.1kgs. If a mattress setting is too high, this can further agitate certain conditions. This was brought to the attention of the interim manager. When we returned on the 11 April and checked the mattress setting again, there was still a difference of 27.1kgs. The interim manager assured us the mattress had been adjusted and correctly set and that it must have been altered. Whilst we were on site, the interim manager introduced a new monitoring and recording sheet to ensure the mattress setting was correctly monitored and provided a record for the visiting clinical professional to review.

People spoken with told us they were happy with the staff and felt staff had the skills and knowledge to support them. One person said, "They [staff] are always there to help you, they are very good." Another person explained, "That one [pointing to a member of staff] is outstanding, does things without having to be asked." A relative said, "You can't fault the clinical care, the staff seem to know what they are doing." The interim manager explained staff members did not complete the Care Certificate but confirmed the training offered reflected the Care Certificate standards. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and effective care. It was noted in the Provider Information Return (PIR) that staff had received training to a minimum of NVQ level 2. The staff we spoke with confirmed they received the necessary training to support them in carrying out their roles. One staff member told us, "I'm happy with the training, it's good and updated every year." Another staff member told us, "I like the fact that the training is face to face and we are all together, the trainers are really good and we have quizzes and if you're not sure you can ask questions there and then." We saw refresher training for staff was reviewed with training scheduled for the months ahead. Staff new to the service explained how they completed their induction training and spent time shadowing another staff member before being permitted to work unsupervised. Staff we spoke with explained they felt supported by the management team and were confident to approach them with any concerns or issues. Staff confirmed they had received supervision, one staff member said, "I had supervision a few weeks ago, but I would also go to the nurses or seniors if I wanted to check anything, I wouldn't wait until my next supervision."

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 people lack mental capacity to make particular decisions, any made on the person's 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We

checked the provider was working within the principles of the MCA. We saw where people lacked mental capacity to make certain decisions for themselves mental capacity assessments had been completed. However, the assessments were generic and we did not always see how the decision had been made or what questions and understanding the person had to make this decision. The interim manager had already taken action to address this issue and introduced a new mental capacity assessment form that was more decision based. The interim manager was in the process of using the form to reassess people's mental capacity where appropriate.

Staff we spoke with gave us examples of how they would obtain people's consent before supporting them. One staff member said, "I ask people what they want and if they are unable to tell me, I look at their facial expressions or their body language." Another staff member told us, "I always ask because you get to know people and understand their needs through their body language or facial expressions." We saw staff encouraged and offered people choices and sought people's permission before supporting them. All of the staff we spoke with identified people who they thought would be at risk of harm if they were not restricted to protect themselves from harm. One staff member said, "We do stop people from doing some things because it's not safe for them." We saw that some people were closely supervised and had been subjected to a restricted practice, in their best interests, to prevent injury to themselves or others. The provider had considered when people were being restricted unlawfully and applications, where appropriate, had been made to the Supervisory Body.

Requires Improvement

Is the service caring?

Our findings

Most of the people and their relatives spoke in a positive way about the staff. One person said, "The staff are absolutely lovely." Another person told us, "I am spoilt, I love them [staff] all for various reasons, I love my tea and I could ask them for it in the middle of the night and it's no problem for them." Another person explained, "Most of them are good, but it can be varied," and another person said, "That staff member does everything with a smile which is nice, not all of them are like that." A relative told us, "I can't fault the staff they are all lovely and very caring." Another relative said, "It's a lovely home, clean, bright and everyone seems to be happy and well cared for." One staff member told us, "I enjoy what I do

Staff spoken with explained how they would make sure they delivered care in a way the person was happy with. If the person was not happy and declined the support being offered, staff told us they would leave the person for a while, then return later to check if the person had changed their mind. We saw staff understood people's communication needs and gave people the time to express their views. Some of the people and their relatives told us staff included them in decisions about their care but some relatives said more could be done to involve them in decisions about their family member's care. For example, a family representative told us, "There have been a number of appointments made with clinical professionals and I haven't been invited to any of them, I know [person's name] best and I should have been consulted." The interim manager confirmed there had been occasions when the representative had not been contacted but had now been addressed; the person's care plan had been updated with measures in place to ensure all those involved with the person's care would be consulted in the future.

People told us they were cared for in a dignified way however, this was not always consistent with what we saw. For example, one person seated in the main lounge was holding their skirt in an undignified way while a staff member supported them to eat their yoghurt. It was 20 minutes later before another staff member finally walked across to the person and crouched down to gently explain to the person they were helping to reposition their skirt to maintain their dignity. At lunch time on the 06 April in the small lounge area, a staff member was heard to say to a person who was becoming anxious and calling out, "Are you kicking off." We discussed our observations with the interim manager who was disappointed but gave us their assurances staff would be reminded about their responsibilities to people.

One person told us, "The staff are very respectful and do respect my privacy." We did see staff knocking on bedroom and bathroom doors before entering although one staff member said to us they would like to see some signage on doors when personal care is being delivered because on occasion they have knocked the bedroom door and been asked to come in and when they have entered the room, care staff had being delivering personal care to the person. The staff member told us, "……..and that's not dignified for people."

Staff we spoke with explained how they supported people who could not always express their wishes. For example, we saw one staff member sit down with a person who was becoming anxious, they took the person's hand and gave them lots of reassurance in the person's preferred language. We could see this helped to comfort the person and eased their anxiety. We later saw the person had their prayer book in their

hand and it was clear this was very important to them. People told us they could continue to practice their religion because a local priest would also visit regularly to give Communion. The provider had catered for people's cultural and spiritual needs.

Staff explained to us how they supported people to make choices and we saw people exercised some choices with regard to their daily routines. For example, we saw one person approached staff for a cigarette when they wanted and walked out to the garden to smoke it. Another person told us, "I tend to get up late and then stay up late." We asked staff how they encouraged people to maintain some independence. One staff member said, "We try to encourage people to do as much as they can like brushing their teeth, combing their hair or washing their face."

People's personal appearance had also been supported, for example a number of ladies had their finger nails painted and some people were dressed in clothing that reflected their ethnicity and culture. One relative explained "We're taking mum to the hairdresser she has her hair done every week."

The bedrooms we were invited into were well maintained by the provider and individualised with pictures and personal belongings that were important to the person. One person told us, "I love my room, I have everything I need." A relative said, "They [staff] are all very good to my mum. She has a nice room, she has her TV and she has some personal bits and bobs."

People told us that their family members were made to feel welcome. We saw there was a constant arrival of visitors. A relative told us "They [staff] don't seem to mind what time you come to visit, I am always made to feel welcome and offered a cup of tea." Another relative said, "There is open access, and I can visit anytime." The home had plenty of areas for visiting relatives to sit and talk, for example in the conservatory, people's bedrooms, the garden or a bistro area where relatives could purchase refreshments and something to eat.

Staff ensured confidentiality was maintained and we saw that staff were discrete when talking to each other in public areas so as not to be overheard. One person told us, "They [staff] don't gossip about each other." Information held about people was kept safe and secure. People's personal information and records were kept in locked cabinets. Only authorised staff had access to this information.

Good

Is the service responsive?

Our findings

People and their relatives told us they had the opportunity to visit and look around the home before making a decision to move in. The Provider Information Return (PIR) stated that a full pre nursing assessment of people was completed by the nurses before admission to make sure the provider could meet people's individual needs. This ensured that any required specific equipment was in place before the person was admitted to the home. We saw individual care plans were in place which reflected people's support needs and detailed people's medical conditions. Our conversations with people confirmed some people, where possible, had been involved in discussing the planning of their care and they had contributed to their care plans. One person said, "Everything is in a book with all their notes about my care." Another person told us, "They [staff] keep you informed about what is happening." However, when we spoke with relatives this was not consistent, one relative told us, "I am happier now because there has been an improvement with the new manager, there were a lot of issues around recording information in mum's notes and they [staff] were not always quick to respond to mum's needs." A representative for another person told us, "I have not always been consulted in decisions about [person's name] care." We spoke with the interim manager about these concerns and we saw meetings had been arranged, or had already taken place, with the respective family representatives to resolve the issues that had been identified. The interim manager continued to explain that since the previous registered manager had left 'a lot of work' had been done by the management team to address concerns. The provider had acknowledged that more could be done to ensure people and family members were involved in discussions about people's care needs and how this could be clearly documented in the individual care plans.

People and their relatives told us staff were generally responsive to their needs. One person told us, "When I press the buzzer sometimes they [staff] come quickly and sometimes they don't." An analysis of the activation of alarms between 04 and 11 April 2017 showed that all emergencies were answered within two minutes with the majority being responded to within one minute. All other calls had been responded to within ten minutes with 85% being responded to within four minutes. This showed that people's requests for assistance were responded to in a timely manner. A relative said, "Every time we've been here we've seen staff react very quickly to people when they've needed assistance." Staff we spoke with was able to provide us with details of people's daily routines and what was important to them and the impact it had on them when staff followed their routines. One staff member told us, "I know what [person's name] likes and they will tell me anyway." Although it was difficult for some people to express how their care was personalised to meet their individual needs, from our observations, we saw that people's care was delivered according to their needs.

The PIR stated the provider had an activities programme in place that was person centred and available six days per week. We found there were two dedicated staff members that planned and delivered a programme of activities for people; with a further two staff to be recruited. We saw there were one to one and group activities offered to people. We saw people were invited and some agreed to participate in board games, card games and light exercise. One staff member told us, "We try to get as many people involved as we can." There were some mixed opinions on the quality of the activities being delivered. One person told us, "All the days are the same, we do get to do some card or board games but the music can be very loud when you're

trying to concentrate." From our observations, the people that chose to participate in the activities had enjoyed themselves.

The PIR stated that complaints were dealt with in a timely manner and that the management team had an open door policy. Some of the people and relatives we spoke with told us they had no complaints but if they did, they would speak with the management team or nursing staff and they were confident the complaint would be addressed. Two family members we spoke with did tell us they had raised some concerns and one complaint was being reviewed at the time of our visit. We could see the provider had investigated the complaints and where appropriate, action had been taken and measures put in place to reduce the risk of any reoccurrence. For example, we spoke with one relative who explained there had been some concerns about their relative's dietary requirements, they continued to tell us, "We met with the manager and we are happy with the improvements."

Requires Improvement

Is the service well-led?

Our findings

The home did not have a registered manager in post, however, there was a deputy manager, an interim manager from one of the provider's other homes available for support and a new general manager had recently been recruited. The deputy and interim managers and nursing staff were responsible for the day to day running of the home but it was the intention of the provider to submit an application for a registered manager. Staff had told us, prior the new manager coming into post and the interim manager 'stepping in' to provide cover, there had been issues with some staff not turning up to work or completing their tasks and a feeling there was a lack of leadership and supervision. Staff told us they now had a clearer understanding of what was expected of them and all but one felt the atmosphere had improved. One staff member told us, "We [staff members] are still getting to know each other and our ways of working but we now feel we are a team and we will get there, it is much better now." We saw the management was approachable and that people and relatives approached staff members and management team freely during our visit. People and relatives spoke positively about the new management team, one relative said, "There has been a definite improvement."

All but one of the staff members we spoke with confirmed they felt confident to approach the management or nursing team if they had any concerns or worries. Staff we spoke with confirmed staff meetings had now taken place and we looked at minutes from the meetings and we saw meetings had been used to discuss issues around the running of the service and how improvements could be made.

A range of audit checks were carried out to monitor the quality and safety of the home. These included audits looking at the arrangements for people's medicines, risk assessments, recruitment of staff, care plans and health and safety. By having quality assurance systems in place, this protected the safety and welfare of people living in the home. We saw the audit checks were completed and were generally up to date. However, there was some inconsistency with the reviewing of care plans and risk assessments. We noted there was also some inconsistency with totalling the amount of fluid intake for some people that required their intake to be monitored accurately. We also found that there was some inconsistency with recording people's dietary needs, for example in two of the plans we looked at one person's needs were recorded as requiring a pureed diet when they required fork mashable and a second person's needs were recorded as requiring a soft diet but on their risk assessment, no difficulties with eating their food had been identified. We spoke with the interim manager about the inconsistencies we had found and they explained since the previous registered manager had left, some care plans and risk assessments had not been recently reviewed. However, the provider had introduced 'Resident of the Day' where staff would complete an enhanced review for that person. For example, this would include the person's bedroom environment, a preferred meal of their choice and their individual care needs and wishes. The interim manager explained in practice, they would ensure that within a short period of time, everyone living at the home would have had a comprehensive reassessment and all the recorded information on their care plans and risk assessments would be checked for any anomalies and updated accordingly.

The Provider Information Return (PIR) we requested had been completed and submitted on time. It contained information relevant to the service and the improvements required. These were consistent with

our findings and what we were told by people, relatives and staff.

Most of the people and the relatives we spoke with were complimentary about the service and that they would speak with members of the management and nursing team if they needed to. One person told us, "I am very happy here." Another person explained, "It is very nice here and everyone is very kind." A relative told us, "Just look around you, it's great, you have the restaurant, it spotlessly clean and mum's very happy here, what more could you ask for." A staff member said, "We have had our problems but things are much more settled now and I like it here."

The PIR stated the provider had a comments box where visitors could leave comments, compliments or complaints about the service. We saw the comments box had also been used by staff to raise issues anonymously if they wished. One relative told us, "I have been asked a couple of times is there anything that could be done differently." Another relative said "I have completed a survey." As the home has been open less than a year and the registered manager had left, meetings with people living at the home and their family members had not always been frequently held. The interim manager had now addressed this and had recently held a 'relative/resident' meeting. We also saw that a survey had been conducted and we discussed with the interim manager how they had responded to suggestions received. For example, one suggestion was to make the environment more homely. The provider had purchased a number of pictures now displayed on all three floors. Feedback to us from visitors was positive about the quality of the pictures. There were also a number of comments made about staffing numbers. The provider had responded by increasing the number of staff members employed at the home.

Staff we spoke with told us they would have no concerns about whistleblowing and all but one staff member felt confident to approach the management team, and if it became necessary to contact Care Quality Commission (CQC) or the police. The provider had a whistleblowing policy that provided the contact details for the relevant external organisations. Whistleblowing is the term used when an employee passes on information concerning poor practice.

It is a legal requirement to notify the Care Quality Commission of any significant incidents or accidents that happen as this helps us to monitor and identify trends and, if required, to take appropriate action. We had been notified about significant events by the provider and we saw where accidents and injuries had occurred appropriate treatment and observations had been put in place to ensure the person's safety and no long term injuries had been sustained. We found that, where appropriate, investigations into any safeguardings had been conducted in partnership with the local authorities to reach a satisfactory outcome.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found that the provider was working in accordance with this regulation within their practice. We also found that the management team had been open in their approach to the inspection and co-operated throughout. At the end of our site visit we provided feedback on what we had found and where improvements could be made. The feedback we gave was received positively with clarification sought where necessary.