N. Notaro Homes Limited

Clarence Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 1 December 2017. The previous comprehensive inspection was undertaken in November 2016. At this inspection the provider had breached two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These breaches related to staffing and good governance. The service was rated as 'Requires Improvement'. At this inspection we checked whether improvements had been made and the service was no longer in breach of the regulations.

You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Clarence Park, on our website at www.cqc.org.uk.

Clarence Park is registered to provide accommodation for persons who require personal or nursing care for up to 43 people. The service cares for older people, some of whom are living with dementia. At the time of our inspection there were 39 people living in the service.

There was a registered manager in post. 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.

At our last inspection in November 2016 we found there were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of people using the service. During this inspection we found some improvements had been made but this is an area that is still work in progress. The service is undertaking a recruitment drive.

At our previous inspection we found inconsistencies in people's care records and in the frequency of care plan reviews. Although improvements had been made, this area still required further development. Some of the care plans we looked at did not provide enough detail for staff on how to meet people's physical needs. Despite the lack of some detail within the plans, staff knew people well. They were able to discuss at length with us people's life histories and their physical, mental and social needs and preferences.

At our previous inspection the provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. Although sufficient improvements had been made, this area required further development. Some shortfalls identified during this inspection had not been identified. In most cases the quality assurance process was more detailed and actions were taken in a timely manner. The service had an action plan in place which identified issues that needed to be taken forward within stated timelines.

Medicines were in the main managed safely but there were areas which required improvement, such as the need to update each person's 'as required' medicines records.

Care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. In most cases these were detailed and included guidance for staff on how to manage the risks of harm to people.

Regular maintenance and equipment audits relating to fire safety records, maintenance of safety equipment, gas safety, call systems, portable appliance testing (PAT) were undertaken.

People's rights were upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

People received effective support from staff that had the skills and knowledge to meet their needs. We saw that the service's induction was aligned with the Care Certificate. The Care Certificate is a modular induction which introduces new starters to a set of minimum working standards. Staff received on-going training to enable them to fulfil the requirements of the role.

People were supported to have enough to eat and drink. People were assessed for the risk of malnutrition and when required specialist advice and support was sought.

People spoke positively about the staff. Comments included; "Staff are alright, lovely girls"; "Everyone is cheery and friendly." Staff understood the importance of maintaining people's independence where possible.

People had access to a varied activities programme. People maintained contact with their family and were therefore not isolated from those people closest to them.

All of the staff we spoke with said they enjoyed working at the service. They said morale was "really good" and "we pull together." They spoke highly of the registered manager and the deputy manager. The registered manager encouraged an open line of communication with their team. Regular staff meetings were held.

People were encouraged to provide feedback on their experience of the service. We viewed the feedback from the 2017 questionnaire which sought people's feedback on the staff, individuality, the building and surroundings and activities. On all areas the service rated as either good or excellent.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels were not always maintained in accordance with the assessed dependency needs of the people who used the service. The service is currently undertaking a recruitment drive.

Medicines were in the main managed safely but there were areas which required improvement.

Staff had attended safeguarding training to protect people from harm and abuse.

Regular maintenance and equipment audits were undertaken. Actions were taken forward in a timely manner.

Is the service effective?

Good

The service was effective.

People's rights were being upheld in line with the Mental Capacity Act (MCA) 2005.

Staff were supported through a training and supervision programme.

People were supported to have enough to eat and drink.

People had access to on-going healthcare.

Is the service caring?

Good

The service was caring.

People spoke positively about the staff.

Staff understood the importance of maintaining people's independence where possible.

People's dignity was maintained and respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

At our previous inspection we found inconsistencies in people's care records and in the frequency of care plan reviews. Although improvements had been made this area still required further development.

The provider had a system in place to receive and monitor any complaints.

People had access to a varied activities programme.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

At our previous inspection the provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. Although sufficient improvements had been made this area required further development.

The registered manager encouraged an open line of communication with their team.

All of the staff we spoke with said they enjoyed working at the service. They spoke highly of the registered manager and the deputy manager.

People were encouraged to provide feedback on their experience of the service.

Clarence Park

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. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced inspection on 1 December 2017. The inspection was conducted by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

During the inspection we spoke with 16 people, eight members of staff, three visitors, the registered and regional manager. We observed part of the medicine round and interactions between staff and people in the communal areas of the service. We reviewed eight care plans. We also reviewed the provider's audits relating to the health, safety and welfare of people who use the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were in the main managed safely but there were areas which required improvement. We observed parts of two medicines rounds. Of the two nurses administering medicines, one was a new employee and one was an agency nurse on their second shift. Neither was entirely familiar with people using the service, but both took measures to ensure that they were able to identify people correctly. The service used an electronic medicines administration record (EMAR) system for medicines. These showed that people received their medicines as prescribed. Regular stock checks were carried out. Medicines that were no longer required were safely disposed of.

Medicines were in the main stored safely. The temperature of the medicines fridge and the medicines room was monitored. The fridge temperature log showed that items for refrigeration were stored within recommended temperatures. Clinical room temperature logs showed that on some occasions the temperature had exceeded the recommended 25 degrees centigrade. Staff had usually documented any action they had taken in these instances, for example, putting a fan on. However, this was not consistent. Additionally, staff did not always record the temperature after the use of a fan to assess whether the temperature had dropped significantly.

Staff said that two people were having their medicines crushed; however, there was nothing documented to indicate that pharmacist advice had been sought. Crushing medicines can alter their mode of action and so it is important to have a pharmacist confirm it is safe to do so. However, there was nothing documented in the EMAR to indicate these people had medicines crushed. Additionally, there was nothing documented in the care plans. The information provided by the staff members did not correlate with the information held in the records. The registered manager agreed to take this forward as a matter of priority. They told us that they had sought advice from the GP and pharmacist and this would be documented. There was no documentary evidence provided at the inspection.

Some people were prescribed additional medicines on an as required basis (PRN). It is good practice to have PRN protocols in place that detail when and why people might require additional medicines in order to identify trends and people's personal preferences. However, there were none in place. The registered manager said there had been an issue with the EMAR system which had resulted in all of the protocols being erased from the system and they were in the process of rewriting these. The registered manager told us they are in the process of prioritising the rewriting of the PRN protocols. We found no evidence to suggest that people were not receiving 'as required' medicines. People told us they received their medicines on time and when needed.

At our last inspection in November 2016 we found there were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of people using the service. During this inspection we found some improvements had been made but this is still work in progress.

Staffing levels were regularly assessed by the registered manager by using the provider's staffing dependency tool. The registered manager told us that the target staffing level had recently increased to

eight care staff in the morning; seven care staff during the afternoon and four care staff at night. The dependency tool determined that two nurses should be on duty during the day and one during the night. Staffing rotas demonstrated that care staffing levels did not always match the recently assessed dependency needs of the people who used the service. To address this matter the service is currently undertaking a recruitment drive, using existing staff to cover shifts and when needed using agency staff.

Staff told us that staffing levels were usually sufficient to meet people's needs. Comments included "We have good and bad days. People do ring in sick and some staff do extra shifts to cover this, or we use agency. But there should be eight of us on the floor and today we only have six"; "When everyone turns up, yes there's enough. But when people go off sick they do try and cover it"; and "We work well as a team. We all pull together."

We did note from staff meeting minutes and the quality performance and compliance reviews that concerns had been raised regarding call response times. In order to address this matter staff are required to carry pagers at all times to allow them to respond to call bells more quickly. Since our previous inspection, call bell response times had improved significantly from an average response time of 12.5 minutes to the majority of calls being answered within the provider's six minutes target. The calls that exceeded the six minute target and those that had been reset in close succession were reviewed by the manager and raised with staff. Their reviews resulted in the re-introduction of the pager system and their proposal of the need to increase staffing levels being agreed by the provider. The service now deployed two members of staff to answer call bells via the pagers at the identified busiest times.

People provided mixed comments on staffing levels but told us they felt safe. Comments included; ""I feel safe knowing staff are around day and night"; "They are very short of staff, but I don't feel rushed"; "They have plenty of staff – response time is always within two minutes. Only when staff are off sick is there a problem" and "When I ring a bell they come quickly, but then say they will be back shortly. This can be up to an hour later. Yesterday was very bad, I had to wait two hours for someone to get me out of bed." The latter person's perception of the call bell response time was not supported by the call bell response time log evidence. On the previous day the log highlighted that some calls were responded and reset in close succession. The longest period that a call was fully resolved was 10 minutes. In that period staff had been in the person's room and reset the call bell four times.

Staff had attended safeguarding training to protect people from harm and abuse. All of the staff we spoke with knew how to recognise signs of abuse and how to report concerns. Staff were also familiar with the term whistleblowing. This is a process for staff to raise concerns about potential malpractice at work. Staff told us that they would feel confident to discuss any concerns that they may have about poor care with the registered manager and they would be listened to.

Care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. In most cases these were detailed and included guidance for staff on how to reduce the risks of harm to people. When staff needed to use equipment to move people the type of hoist and sling required was listed. When people were at risk of pressure sores, specialist equipment was identified, such as air mattresses and pressure relieving cushions. When people needed assistance to change their positions, the required frequency was documented. Position change charts showed that people had their positions changed regularly.

In other cases some of the plans did not reflect the care people were having. For example, one person had been assessed as being a high risk of falls. The plan guided staff to "ensure sensor mat in situ to alert the staff." We observed this person and saw they were sat in a chair in their room, but the sensor mat was beside

the bed on the other side of the room. This meant that if the person did stand up, they would not necessarily activate the sensor mat. When we discussed this with staff, they said the person was more able to mobilise independently during the day, and only needed the mat at night, to alert staff if they got out of bed. However, this was not clearly documented in the plan and potentially placed the person at risk of harm. However, the registered manager told us that it was documented on their bed safety care plan that the alarm matt was in situ for night time.

Care plans contained records of any falls. The majority of these showed that people had been assessed for signs of injury and that care plans had been reviewed when necessary. However, we did see that one person had fallen on 29 November 2017, but the fall report had not been completed in full because staff had not documented that they had assessed the person for any injuries or any required action. Another person had fallen the night before our inspection. Staff had documented in the daily notes "unsettled until 01.30, had a fall, put back to bed and appears to have slept well since". However, this had not been documented in the falls record. The registered manager told us this matter would be addressed.

Apart from the noted falls exceptions there were arrangements in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms identified the events leading up to the incident, steps taken to avoid the incident, behaviour, intervention and reflections and staff de-briefing. Following a paramedic not being dealt with effectively by staff on arrival the registered manager introduced a new staff protocol when dealing with the emergency services. This included the nurse delegating tasks to staff such as meeting the crew, gathering the relevant paperwork and preparing the person to be transported from the service. The registered manager told us that the new procedure was more streamlined. Staff worked collaboratively and were aware of their respective responsibilities.

Recruitment checks had been consistently carried out in accordance with the provider's policy. Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with vulnerable adults. Where staff were not deemed competent to undertake their role concerns were taken forward in accordance with the provider's disciplinary protocol.

People were largely cared for in a safe and clean environment. During a walk around the building with the registered manager we did note exceptions that were addressed immediately. One of the bathrooms had rubbish and hand towels left on the floor. The bath and air filter were dusty. The registered manager told us that the domestic supervisor was currently off sick. Staff knew how to protect people from the risk of infection. We saw that staff had access to personal protective equipment (PPE) such as aprons and gloves. Apart from the exceptions identified rooms were well maintained, hygienic and odour free. The kitchen had a five star rating awarded by the Food Standards Agency.

A full time maintenance person was employed by the service. Regular maintenance and equipment audits relating to fire safety records, maintenance of safety equipment, gas safety, call systems, portable appliance testing (PAT) were undertaken. Contingency plans were in place in case the service needed to be evacuated and each person had a Personal Emergency Evacuation Plan (PEEP) in place to provide information to emergency services in the event of an evacuation. Where maintenance actions were required they are taken forward within a reasonable timescale and recorded in the maintenance log book.

Good

Is the service effective?

Our findings

People's rights were upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In people's care plans we saw information about their mental capacity and that Deprivation of Liberty Safeguards (DoLS) were being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

Consent to care was largely sought in line with legislation and guidance. When people lacked capacity, best interest decisions were made. However, it was not always clear how these best interest decisions had been reached because there was limited information recorded. For example, one person had been assessed as lacking the capacity to consent to the use of a sensor mat. Staff had documented "Following the amount of falls, it is within [Person's name] best interests to have the sensor mat in place". The actual decision making process was unclear. Where people had capacity to do so, they had consented to their care. This included, for example, the use of photographs, and bed rails.

Staff demonstrated a good understanding of the requirements of the Mental Capacity Act and understood the need to gain people's consent prior to assisting them. Throughout the day we observed staff seeking people's consent and views before assisting them. For example, we saw one member of staff pushing one person in a wheelchair into the dining room at breakfast time. They asked them "Where would you like to sit?"

People received effective support from staff that had the skills and knowledge to meet their needs. We saw that the service's induction was aligned with the Care Certificate. The Care Certificate is a modular induction which introduces new starters to a set of minimum working standards. Staff received on-going training to enable them to fulfil the requirements of their role. We reviewed the training records which showed mandatory training was completed in key aspects of care to ensure staff and people at the service were safe. Modules included; equality and diversity, fire safety, infection control, moving and handling and first aid.

People's needs were met by staff that were effectively supported and supervised. Supervision is where staff meet one to one with their line manager. Conducting regular supervisions ensured that staff competence levels were maintained to the expected standard and training needs were acted upon. Staff felt they received adequate training and supervision to undertake their role. Staff told us; ""This was my first job in care and so I shadowed someone else for a while"; "supervision sessions are held every three months"; and "If we have a problem between supervisions, we can go and speak with the manager or the deputy." People felt confident that staff were in the main skilled, well trained and competent when providing care. Comments included; "Some staff are competent, the regular ones, they are alright"; "Very good level of staff competency, generally"; and "Not bad, some are better than others."

People were supported to have enough to eat and drink. People were assessed for the risk of malnutrition and when required specialist advice and support was sought. Plans detailed people's preferences and any

other requirements. For example in one person's plan it had been documented that they preferred to eat using a teaspoon and preferred to drink from a beaker without a lid. One person had hearing difficulties and the plan guided staff to write down meal choices for the person. In another person's plan staff had documented "Eats quite slowly so should be served first so that she doesn't feel rushed". When people were having their food or fluid intake monitored, the charts we looked at had been completed in full. Where required people's weights were monitored.

The chef demonstrated a sound understanding of people's specific dietary requirements, such as diabetes, textured diets and allergies and these were accommodated. We observed people being offered choices of main meals at lunch time. People provided positive comments on the food. Comments included; "At mealtimes I ask for a little of each of the choices"; "I only eat chicken and fish and they don't adapt to my likes well"; "The chef does special meals for me. I only like salad and he does me cheese or egg salad"; "The chef spoils me because I ask, most other people grumble and say nothing"; and "Food is excellent, too much, but tasty."

People had access to on-going healthcare. Records showed that people were regularly reviewed by the GP, physiotherapist, dentist, dietician, tissue viability nurse and the mental health team. Transfer of Care documentation was in place for when people moved between services. This meant that when people went to hospital for example, that the hospital was provided with information about people's needs and medicines. The service were in the process of fully implementing the National Early Warning Score (NEWS). NEWS alerts nursing staff to a deterioration in people's health and prompts them to arrange a medical review.

Good

Is the service caring?

Our findings

People spoke positively about the staff. Comments included; "Staff are alright, lovely girls"; "Everyone is cheery and friendly"; "One big happy household, staff are friendly and helpful"; "The carers are very nice and can't do enough for you"; and "I have two very good male helpers." One person in the dining room told us; "I've been living here for three years. I like going to bed early. They help me with my personal care. The staff are all lovely." The service had also received a number of compliments. Examples of recent compliments were; "Thank you seems too small a gesture – the love and attention that you all gave my Mum during her short stay was second to none"; and "The comfort, care, kindness and compassion received by [person's name] from you all will be long remembered and we are truly grateful for the peace of mind this gave us for the times we could not be with her."

During lunch people were offered choices of food and drink. There was a relaxed social environment where people communicated with each other and sat with their peers. People joined the dining room at different times and were not rushed by staff. Condiments were available on the table. One person requested alternative food from the menu choices and this was accommodated by the chef. People were encouraged to eat independently and provided assistance where required. Specialist equipment was provided to assist people to eat independently, such as plate guards and adapted utensils. When a person asked for help they were assisted by a member of staff to make them more comfortable at the dining table.

Staff were attentive and asked about people's welfare. Staff were not intrusive and where appropriate were leaving people to enjoy their lunch. People were asked whether they would like to wear protective clothing and their decisions were respected. One person was getting distressed because they wanted to see their relative so a staff member reassured them and offered to take the person to call their relative.

Staff understood the importance of maintaining people's independence where possible. One staff member told us; "I always encourage people to do as much for themselves as they can." Two other members of staff told us about a person with a significant improvement in their well-being and independence. They told us; "[Person's name] at first would not drink from a cup and would only use a spoon. They were on a soft diet. Now he drinks for himself and following an assessment (from a heath professional) they are no longer on a textured soft diet. He was deemed as being on end of life care but that is no longer the case. We enable independence. If they can do it, they do it. If people need assistance, we will assist."

People's dignity was maintained. Staff understood how to be respectful. One said "If someone had an accident for example, I don't make a song and dance about it. I would take them to one side discreetly, and speak out of ear shot." Documentation in care plans showed that people were asked for their thoughts on terms of endearment such as darling or sweetheart. This ensured that staff addressed people correctly.

Staff spoke positively about their roles. Comments included "We know our residents and their needs. We understand them. Residents feel part of the community here and well cared for. They've told me that"; "I love working here. I make sure people are well looked after"; and "We put in extra for the residents. I came in last night on my day off to take people out."

We observed staff responding to people's needs in a timely and effective way. For example, when one person was shouting, staff got down to the person's level and calmly explained why they needed them to stop shouting. They stayed talking to the person until the situation was resolved. On another occasion we observed another person calling out. Again, we saw that staff provided calm reassurance.

People's choices and preferences had been taken into consideration, for example, in relation to whether they preferred to spend time alone in their rooms or to be in communal areas with other people. Staff respected people's privacy. They said if people wanted to be left alone, they would respect that. One said "If someone wants to be left alone, we can put a sign on the door."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found inconsistencies in people's care records and in the frequency of care plan reviews. Although improvements had been made this still required further development.

People's physical, mental health and social needs were fully assessed prior to moving to the service. However, some of the care plans we looked at did not provide enough detail for staff on how to meet people's physical needs. In one person's plan it was documented that they were "prone to urinary tract infections", but the signs and symptoms for staff to observe for and the preventative actions to be taken had not been documented. We noted that one diabetes care plan did not always detail the signs and symptoms of low or high blood sugar for staff to be aware of, or describe the action they needed to take. This was of particular relevance because the person did not always adhere to a diabetic diet. Following the inspection the registered manager advised that this information was held on a separate sheet in people's care plans from the individual's GP. During the inspection we were not alerted to a separate sheet regarding this information.

One person sometimes displayed behaviours that staff and others using the service might find upsetting. The plan for this person provided limited guidance for staff on how to manage this; it had been documented, "reassure with explanation and distraction" but there was no detail of how to provide reassurance and what type of distraction worked best. There was also no information about what might trigger the behaviour. We did observe that the person was having one to one support from staff, which was a new level of support. The person was also being reviewed by the Mental Health team regarding additional support and provided advice on the day of our inspection regarding the person's needs. Despite the lack of information in the plan, staff knew this person well. We observed how staff interacted with them, and when they displayed some behaviour that might challenge, staff reacted in a proactive way, speaking calmly and explaining why they needed the person to stop what they were doing.

Other plans we looked at for people who sometimes displayed signs of anxiety were detailed. Any known triggers were listed and the steps staff needed to take to provide reassurance were clearly detailed.

Wound care plans were very detailed. They contained photographs of people's wounds and the wound dressing plans were documented. This meant it was easy for staff to identify when wounds improved or deteriorated.

Some sections of the care plans we looked at were more person centred than others. For example, nutrition plans detailed people's preferences and communication plans detailed how staff should ensure that people could communicate and be understood. However, other sections of the plans were not as person centred. For example, personal hygiene plans did not always detail people's clothing preferences or whether they liked to wear jewellery or makeup. Although the majority of hygiene plans detailed people's preference for a bath or shower, this was not consistent. In one plan it had been documented "arrange a day and assist with a weekly bath" which did not reflect a person centred approach. When people had expressed a preference for a bath or a shower, records did not always reflect these had been provided. Staff said people did have

regular baths and showers but these had not always been documented.

When people had sensory losses such as poor hearing or eyesight, the plans detailed how staff should communicate with people. This included details such as "speak slowly, use short sentences" and "will make good eye contact with you when wants to say something. Get down to eye level, maintain eye contact whilst waiting."

Plans contained details of people's lives prior to moving to the service; some people had written these themselves and some had been assisted by staff or family members. Staff we spoke with knew people's needs and understood how best to meet them. They knew about people's life histories. One staff member said "I get the luxury side of this work. I feel privileged because I get to give one to one care and really get to know them."

There was evidence within the plans that people and their relatives had been involved in care reviews. People's and their relative's comments included; "I have it in my room"; "I've heard of my care plan and may have helped in writing it"; "I was asked about my care plan. I haven't seen it, but my daughter looks at it"; "We worked out my care plan together and went through to update just last week"; and, "I've been here ten years, I was involved in my care plan and I know what it is." At times it was unclear how thorough the reviews were because actions had not always been noted as completed. For example, in one plan it had been documented on 23 May 2017 that a referral had been made to the community physiotherapist, but there was nothing else written to confirm this had happened or what the outcome was. In another plan it had been written that the person's behaviours should be monitored to identify any patterns or triggers, but there were no further entries to confirm if this had happened. The registered manager agreed to review these records to ensure they were up-dated to reflected people's current needs.

There was advanced decision care planning documentation in place but this had not always been filled in. This meant that people's choices and preferences for their end of life care would not be available for staff when the time came.

Despite the lack of some detail within the plans, staff knew people well. They were able to discuss at length people's life histories and their physical, mental and social needs and preferences. One member of staff told us; "I am confident that as a team we know people really well". The registered manager agreed to address the inconsistencies in the records and ensure they correlated with the detailed knowledge of the staff.

People had access to a varied activities programme. On the previous evening some people attended the turning on of the Christmas lights in the town and did some shopping. Although cold, people told us they thoroughly enjoyed the outing. One person told us; "I really enjoyed last night, it was a lot of fun." On the day of our inspection an external entertainer was singing and playing the guitar. The activities coordinator was passionate about their role and had arranged a number of additional festive activities. These included a Christmas jumper day, a shoe, carol service, choir visit, raffle and Christmas Eve buffet. The activities programme offered on a weekly basis included arts and crafts, exercises, singing and reminiscing sessions. Owing to their interest in writing one person also assisted the service in producing a newsletter. Volunteers also came to the service to take people out and this extended their links with the community.

People maintained contact with their family and were therefore not isolated from those people closest to them. Visitors were welcomed at any time. The registered manager told us that some family members were joining the service on Christmas day. We observed visitors being offered tea and cake. One visitor told us; "I visit five days a week and I'm always welcomed. They look after [person's name] well. The staff are great."

The provider had systems in place to receive and monitor any complaints that were made. People told us that they would know how to raise a complaint and feel they would be listened to. Where complaints had been made they were taken forward and actioned, such as providing compensation for laundry.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection the provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. At this inspection sufficient improvements had been made but this area required further development. Some shortfalls identified during this inspection had not been identified. We noted that advanced care planning was not part of the provider's audit tool. Therefore, the lack of these plans had not been identified and taken forward. The registered manager provided assurances that the shortfalls identified at this inspection would be addressed as a matter of priority.

In most cases the quality assurance process was more detailed and actions were taken in a timely manner. Regular performance and compliance reviews were conducted and they reviewed areas such as health and safety, infection control, wounds, nutritional needs, staffing, cleanliness, suitability of equipment, complaints and governance. The latest audit conducted in August 2017 recognised that people's needs were not being met in a timely manner and this led to the provider agreeing to increased staffing levels. The registered manager was conducting a recruitment drive to ensure people's care needs were being met. It has yet to be fully resolved but there were in the main contingency plans in place, such as using existing and agency staff to cover shifts. The service also has an action plan in place which identified issues that needed to be taken forward within stated timelines. This included the need to complete a refurbishment programme in parts of the building.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We found that the registered manager had sent appropriate notifications to us.

All of the staff we spoke with said they enjoyed working at the service. They said morale was "really good." They spoke highly of the registered manager and the deputy manager. Comments included; "The manager is very approachable and very visible" and "The deputy is very hands on." The registered manager encouraged an open line of communication with their team. Regular staff meetings were held. We viewed minutes of the previous staff meeting and issues directly involving the running the home were discussed, such as maintenance, health and safety, infection control and room audits. This ensured staff were kept up-to-date with operational issues.

The service ensured that daily handovers were undertaken at a handover meeting. A nurse also completed a report following each shift. The report identified issues which staff needed to be aware of such as hospital admissions and actions required following health professional visits. This meant that staff could refer to them when required and they were fully informed of people's needs.

People were encouraged to provide feedback on their experience of the service. The service had implemented a resident of the day system. This involved reviewing the care plan with the person and ensuring that their needs were met to their satisfaction, undertaking a deep clean of their room and offering

a choice of something special to do for that day. Resident meetings were held regularly. Issues discussed included menus, staffing, activities and maintenance. One person told us; "At residents meetings I pursue what I care about. But not everyone can be happy at once." We viewed the feedback from the 2017 questionnaire which sought people's feedback on the staff, individuality, the building and surroundings and activities. On all areas the service rated as either good or excellent.